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HEALTH CARE ACCESS BARRIERS

The case of internal migrants working in the construction sector in a Southwestern Indian city

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ABSTRACT

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In this Master's thesis I examine the barriers internal migrants working in the construction sector in India face in their access to health care services. The data of this study was gathered by interviewing fifteen internal migrants who work at construction sites in Manipal, India. This group is in a vulnerable position regarding access to health care. Many social services in India are state based, and therefore migrants are often left excluded from them. Additionally, employment in the construction sector is mostly informal, which further excludes them from social security based on formal employment arrangements.

Access to health care is fundamental for sustaining and improving the health of people. The poor status of access to health care services in India is recognized by both research and the government. It hinders India's possibilities to reach its goal of universal health coverage. Access to health care is a combination of different factors such as service availability, financial factors and quality of services. Both supply side factors, such as availability and operating hours of and distance to services, as well as demand side factors, such as type of employment and income of the patients, constitute access to health care.

I analyzed the data of this study using the method of theory-guided content analysis. I use the health care access barriers model (Carrillo et al. 2011) to explore the financial, structural and cognitive barriers internal migrant workers face in access to health care. The analysis shows that there are multiple different barriers and that they are connected to each other. However, they are not the same for all, as people's resources and characteristics differ and thus, they meet different barriers.

The analysis also shows that widespread distrust in public health care services hinders internal migrant workers' access to health care. Among the participants of this study, public health services were seen as worse in quality and workers being less responsible compared to private services. In this way, structural and cognitive barriers, for their part, created distrust in public health care services. Distrust created a financial barrier to services as people opt for private services, which are more expensive than public ones. At the end of the analysis, I provide a revised version of the health care access barriers model with distrust in public health care services as an additional component. These findings regarding structural, financial and cognitive barriers and the role of trust in public health care services are important for both research and policy. Understanding the complexity of health care access can be used to ensure the access to health care of vulnerable people in India.

Keywords: health care services, health care access, informal work, internal migration, India

TIIVISTELMÄ

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Tässä tutkielmassa tutkin sitä, millaisia esteitä rakennusalalla työskentelevät maan sisäiset siirtolaiset kohtaavat terveyspalveluihin pääsyssä Intiassa. Tutkielman aineisto on kerätty haastattelemalla viittätoista rakennusalalla työskentelevää maan sisäistä siirtolaista Intian Manipalissa. Tämä ihmisryhmä on terveyspalveluihin pääsyn kannalta haavoittuvassa asemassa. Monet Intian sosiaalipalveluista ovat osavaltiokohtaisia, ja siirtolaiset jäävät niiden ulkopuolelle. Lisäksi Intian sosiaaliturva perustuu vahvasti formaaleihin työsuhteisiin, joten tutkimuksen kohderyhmä jää usein sen ulkopuolelle, sillä rakennusala kuuluu informaalin työn piiriin.

Terveyspalveluihin pääsy on oleellista ihmisten terveyden edistämiseksi ja ylläpitämiseksi. Pääsy terveyspalveluihin on heikkoa Intiassa, ja ongelma on tunnistettu sekä tutkimuksessa että maan hallinnossa. Se vaikeuttaa Intian pyrkimystä tavoittaa yleiskattava terveydenhuolto. Terveyspalveluihin pääsy muodostuu useasta osasta, kuten palveluiden saatavuudesta, taloudellisista seikoista ja palveluiden laadusta. Sitä rakentavat sekä tarjontatekijät, kuten palveluiden saatavuus, aukioloajat ja etäisyys, että kysyntätekijät, kuten asiakkaiden työ ja tulot.

Analysoin tutkielman aineistoa teoriaohjaavan sisällönanalyysin keinoin. Käyttäen *health care access barriers* –mallia (Carrillo et al., 2011) tarkastelen taloudellisia, rakenteellisia ja kognitiivisia esteitä, joita siirtolaistyöntekijät kohtaavat terveyspalveluihin pääsyssä. Analyysini osoittaa, että esteitä on monia ja ne ovat yhteydessä toisiinsa. Esteet eivät kuitenkaan ole samat kaikille, vaan ihmisten erilaiset resurssit ja ominaisuudet muovaavat sitä, millaisia esteitä he kohtaavat.

Tutkielman analyysi osoittaa lisäksi, että laaja epäluottamus julkisia terveyspalveluja kohtaan heikentää tutkimuksen kohderyhmän pääsyä terveyspalveluihin. Tutkimuksen osallistujat näkivät julkiset terveyspalvelut laadultaan heikompina ja vähemmän vastuullisina kuin yksityiset palvelut. Rakenteelliset ja kognitiiviset esteet palveluihin pääsyssä siis luovat epäluottamusta julkisia terveyspalveluja kohtaan. Epäluottamus puolestaan synnyttää taloudellisia esteitä palveluihin pääsylle, sillä ihmiset hakeutuvat yksityisten palveluiden piiriin, ja ne ovat julkisia palveluita kalliimpia. Analyysini lopussa esittelen uuden version *health care access barriers* –mallista, mihin epäluottamus julkisia palveluja kohtaan on lisätty uutena elementtinä. Nämä rakenteellisiin, taloudellisiin ja kognitiivisiin esteisiin sekä julkisiin palveluihin kohdistuvaan luottamukseen liittyvät löydökset ovat tärkeitä sekä tutkimukselle että sosiaalipolitiikalle. Ymmärrystä terveyspalveluihin pääsyn monitahoisuudesta voidaan käyttää varmistamaan Intian haavoittuvassa asemassa olevien ihmisten pääsy terveyspalveluihin.

Avainsanat: terveyspalvelut, pääsy terveyspalveluihin, epävirallinen työ, sisäiset siirtolaiset, Intia

Contents

1. Introduction

Health is a fundamental component of human wellbeing, and health care services play a particular role in fostering and sustaining health (United Nations Development Programme [UNDP], 2014). Where access to health care services is limited or does not exist, the fulfillment of human wellbeing is also limited. This thesis sheds light on the limitations a vulnerable group of people in India, internal migrants working in the construction sector, meet when in need of access to health care.

Equal access to health care services results in improved health outcomes and equity in the society (Planning Commission of India, 2011, p. 6). Universal health policies and adequate resource allocation to health care services help to reduce the vulnerabilities of groups and populations and to create equality in the society. (UNDP, 2014; Yamin, 2016.) Therefore, the provision of access to health care services is a vital question in India which faces a double burden of both communicable and non-communicable diseases as it is going through a demographic transition (Barik & Desai, 2014). The issue of health care access has been recognized as India has made proposals to reach universal health coverage and the government is committed to improving its health care provision to achieve better health outcomes. This includes expanding the coverage of public health care to those who are now unable to use the services. In 2010, a High Level Expert Group (HLEG) on Universal Healthcare Coverage was founded by the Planning Commission of India with a mandate to provide a framework for the execution of universal health coverage in India. (Ministry of Health and Family Welfare, 2017; NITI Aayog, 2017; Planning Commission of India, 2011, p. 1.) Access to health care services is not synonymous to universal health coverage, as the latter also includes aspects such as a healthy living environment and health protection. Access to services, however, is an integral part of universal health coverage. (Planning Commission of India, 2011, p. 3.) In addition to defining barriers in access to health care, this study provides insights to how trust in public health care services is connected to other barriers that hinder access to health care. The issue of lack of trust in the public health care system has also been recognized by the state government (Ministry of Health and Family Welfare, 2017). It is an important factor in health-related policy making, because trust in the health care system results in better health outcomes (Hall, Dugan, Zheng, & Mishra, 2001; Mahon, 2013).

There are hundreds of millions of internal migrants - people moving within the boundaries of a country - and two billion workers in the informal sector globally (UNDP, 2009; International Labour

Office, 2018). In India there are 450 million internal migrants and 420 million workers in the informal sector in the country (Office of the Registrar General & Census Commissioner, 2011a; Office of the Registrar General & Census Commissioner, 2011b). These numbers greatly overlap, as most of internal migrants work in the informal sector (Bhagat, 2016, p.252). Internal migrants working in the construction sector are in the intersection of multiple sources of vulnerability. Migrating to another state or district sets them to a position subordinate from those native to the area, as they are excluded from many public services, public decision making and may face cultural or linguistic challenges (UNESCO, 2013, p. 17). The informal and unorganized nature of the construction sector in India largely excludes workers from the benefits, security and employer responsibilities offered by formal employment. Work in the construction sector is, furthermore, seasonal, temporary and prone to accidents. (Bhattacharyya & Korinek, 2007; Dhas & Helen, 2008; Rajasekhar, Suchitra, Madheswaran, & Karanth, 2008.) This research aims to provide information that can be used to develop public policy that better takes into account the needs of this large group of people and enhances their position in the society.

In this thesis, I examine the barriers internal migrants working in the construction sector face in access to health care. Using the method of theory-guided content analysis, I analyze the interviews of fifteen construction workers who have migrated from other areas of the country. Using the threefold conceptualization of the health care access barriers model (Carrillo et al., 2011), I provide an analysis of financial, structural and cognitive barriers. Furthermore, I elaborate on the role of distrust in public health care services in the context of access to health care and provide a revised version of the health care access barriers model, which includes the dimension of trust. Taking a qualitative approach to the issue allows for an understanding of the complexity of it. I examine how structural, financial and cognitive barriers are in fact connected to each other and also present how migration, informal work and gender relate to these barriers.

The study takes place in the area of Manipal in the city of Udupi, located in the state of Karnataka in India. Karnataka has experienced a rapid rise in the economy, in particular in the IT-sector, which has resulted in the booming construction sector (India Brand Equity Foundation, 2019). Udupi is the headquarters of Udupi district and has approximately 165 000 inhabitants and a diverse economy. Manipal is a town area in the east part of Udupi city. The heart of Manipal is the Manipal Academy of Higher Education with its 28 000 students; students, staff and providers of different services related to the university add up to the clear majority of residents in the area. Manipal is a cosmopolitan town

with a lot of investment in the area. Hence, there are constantly multiple construction projects underway in Manipal, which require workers, many of whom move from other parts of the country.

This thesis does not cover all challenges migrant construction workers face when accessing health care, nor does it intend to claim that all migrant construction workers face all the challenges presented here. As is typical to qualitative research, it gives insights into what are possible barriers in access to health care among the group and how such barriers are perceived by them. Instead of stating that these, and exclusively these, barriers are crucial for all members of this group, it highlights a variety of barriers which should be considered in the planning and implementation of public policy, when aiming at better access to health care, universal health coverage or a more equal society.

In the next chapter, I examine the context of internal migration and construction work in India. I introduce my theoretical foundations of access to health care and trust in public health care services in chapters 3 and 4. After elaborating more on the methodological choices and processes of the study in chapter 5, I move on to present my findings in chapters 6 and 7. I discuss the findings as a whole in chapter 8 and then conclude with recommendations for policy and research in the last chapter.

2. Internal migrants in construction work in Karnataka

Despite low attention compared to international migration, internal migration inside countries is a wide and extensive phenomenon. In 2009, the United Nations Development Programme estimated that there are approximately 740 million internal migrants in the world - and recognized this to be a conservative estimate (UNDP, 2009, p. 1). With its total population of 1,2 billion, India carries a large proportion of internal migrants. Combined with the hundreds of millions of informal workers in the country, the phenomenon at hand is in no way marginal. In this chapter I give an overview of internal migration in India as well as of the informal construction sector. At the end of the chapter I present the profile of the participants of the study from the viewpoint of informal work.

2.1 Internal migration in India

According to the latest official data available from the year 2011, India has more than 455 million internal migrants, more than a third of its total population. About one third of internal migrants move to urban areas. Majority of internal migration in India happens within states; in 2011 only about 13% of internal migrants were inter-state migrants. (Office of the Registrar General & Census Commissioner, 2011b.) Employment is the third most popular reported reason for migration after marriage and moving with the household. However, employment is the most important reported reason among male migrants. (ibid.)

Migration in and out of states is very imbalanced. Karnataka is one of the few states that are classified as in-migrating states. The differences between states reflect the different developmental levels of Indian states: rural and less developed states are net senders of migrants while those that are more urban and developed receive migrants. (Bhagat, 2016, p. 248; UNESCO, 2013.) The cause for this flow of people is that since India's economic liberation and swift toward a neo-liberal economic system in the 1990's, rural distress has grown in the country. During the reform period, inter-state inequality grew. While the economy in urban areas has boomed especially around the IT sector, there are increasing rural-urban disparities in income levels and living conditions. The expenditure on rural development, agriculture and employment programs has decreased and there is a lack of basic social services. Making a sufficient living out of agricultural labor and farming has become more challenging due to rising costs of commodities such as electricity and transport. The open economy

has caused price volatility and declining profitability of certain crops. Growing indebtedness of farmers is facilitated by a steep decrease of formal lending for rural enterprises and agriculture. These issues, together with other financial hardships and challenges related to climate, create distress especially to poor farmers who have very little landowning. (Pal & Ghosh, 2007; Reddy & Mishra, 2008.) This rural distress causes people to migrate from rural to urban areas in search of better possibilities for livelihood – migration is a very usual coping strategy. When studying internal migrants in Bangalore in the state of Karnataka, Premchander *et al.* found that the most important reasons for migration were landlessness or having small land holding; limited or unavailable employment opportunities locally; and low wages. (Premchander et al., 2014, p. 117–118.)

The Indian censuses regard all people moving from a village, town or city to another as migrants. In other words, the classification of a migrant is not bound to geographical distance. In this study, I consider internal migrants people who have moved to Manipal from other states or other districts in Karnataka. Official data (censuses and National Sample Survey data) have also been criticized for not capturing all seasonal and circular migration or short-term migration and thus the numbers might include some underestimations (Bhagat, 2016, p. 241–242; Deshingkar & Akter, 2009, p. 3).

About 65% of internal migrants in India are women (Office of the Registrar General & Census Commissioner, 2011b). Women's migration is connected to caste, cultural norms and the skills needed for work. Women from lower castes are more likely to migrate for work than women from higher castes (Deshingkar & Start, 2003, p. 15). Overall, employment as the main reason for migration is less common among women than men (Deshingkar & Akter, 2009, p. 3).

Premchander *et al.* (2014) have distinguished three categories of internal migrants who move in search of work. The first one (1) is intra-state migrants who mostly move with their family members. Their duration of stay is shorter and their wages lower than those of inter-state migrants. Inter-state migrants move in bigger groups (of usually men) and stay in their place of work for longer periods of time. Those inter-state workers who work on construction sites usually belong to the group (2) with longer stays (up to 5 years) and higher wages compared to other inter-state workers who (3) work in hotels and fishing boats, for example. The participants of this study can be seen as belonging to groups 1 and 2. I elaborate more on their profile later in this thesis.

While migration is important as it creates important sources of income and cash flows, it also excludes people from government services (Deshingkar & Akter, 2009, p. 44–46). Due to the federal system of India, many social services, social protection programs and legal rights are targeted at residents of a state, which excludes migrants from their scope. Education and health services are left out of the reach of migrants due to administrative and regulatory procedures, especially when migrants lack official proof of local residence. (UNESCO, 2013, p. 7-13) Internal migrants are also often excluded from political representation and decision making, such as participating in elections, because they are residing in areas other than their registered districts (ibid., p. 17). Next, I examine how working in the informal construction sector adds to the vulnerability of internal migrants.

2.2 Construction sector in India

Construction – an unorganized sector

The concept of informal or unorganized labor sector is multifaceted in the Indian context. Unorganized and informal are sometimes used synonymously. However, organized/unorganized often refers to the sector and formal/informal to the nature of work. These terms are not always interchangeable as there is much informal employment in the organized sector and also some formal work in the unorganized sector. (National Commission for Enterprises in the Unorganised Sector, 2007, p. 2-3). I use the definitions given by the National Commission for Enterprises in the Unorganized Sector that allow the interchangeability of the terms informal work and unorganized work: *"The unorganised sector consists of all unincorporated private enterprises owned by individuals or households engaged in the sale and production of goods and services operated on a proprietary or partnership basis and with less than ten total workers"* and "*Unorganised workers consist of those working in the unorganised enterprises or households, excluding regular workers with social security benefits, and the workers in the formal sector without any employment/ social security benefits provided by the employers."* (ibid.) I have categorized the population of my study into three groups based on different levels of informality in their employment. I present this three-fold conceptualization later in this chapter.

In 2009-2010, there were more than 380 million workers (84%) in the unorganized sector and about 73 million in the organized sector. Of these workers, 427 million were in informal employment (93%)

and 33 million in formal employment. (Planning Commission of India, 2013, p. 131). Growth on employment in the organized sector comes from informal work (National Commission for Enterprises in the Unorganised Sector, 2007, p. 4), which tells us that the role of informal work is not decreasing, more likely the opposite. The majority of internal migrants work in the informal sector (Bhagat, 2016, p. 252). The construction sector is one of the largest labor sectors in India. Construction work is the second largest category in the sector of unorganized labor, following agriculture. In 2009-2010, there were 44 million workers in the construction sector with an increase of more than 18% in the preceding 5 years. (Planning Commission of India, 2013, p. 160.) In her study Khurana identified three ways for migrants to be employed in construction work: long term assignments by contractors who the migrants know and who had helped them with migration; shorter individual contracts with employers formed in recruitment sites; and as subcontractors (Khurana, 2017, p. 926–927).

Construction - a gendered sector

About 15 % of construction workers are women (Office of the Registrar General & Census Commissioner, 2011a). Women who work in the construction sector are young, rarely over the age of 40. The majority of female construction workers work alongside their husbands in the same construction sites. (Bhattacharyya & Korinek, 2007; Khurana, 2017, p. 926–927.) Migrant women working in construction also often come from the lowest strata of the society. In a study conducted among construction workers in Tamil Nadu, female workers were found to come from lower socio-economic backgrounds than men in terms of literacy and education, poverty and caste (Barnabas, Anbarasu, & Clifford, 2011, p. 222). In another study, as many as 95 percent of interviewed females working in construction were illiterate (Bhattacharyya & Korinek, 2007, p. 520).

The larger subordination of women in India is embedded also in the construction sector. Multiple studies have shown that in construction, men earn almost double the amount that women do. A large majority of women are getting paid less than the minimum wage. Women are also rarely compensated for extra-work (Barnabas et al., 2011, p. 225; Baruah, 2010; Bhattacharyya & Korinek, 2007; Khurana, 2017, p. 929.) Women are often unskilled workers, and this affects their role in the construction sector. (Baruah, 2010, p. 33–36.) The earnings of skilled laborers have risen while those of unskilled laborers haven't (ibid., p. 38). Even though the income of construction worker women

rises along acquired skills, men are paid more for doing the same job as women. Therefore, the division of skilled and unskilled work does not fully explain the gender pay gap. (Barnabas et al., 2011, p. 225.) This reflects the overall situation in India: the World Economic Forum reports that in India the wage equality of men and women in similar work is 0.62 (on a scale from 0 to 1) (Schwab et al., 2017, p. 176).

Discriminatory attitudes towards women and their capability to work in the construction sector hinder women's employment possibilities. Women are seen as physically and mentally incapable of skilled work and this view has been used to justify different wages and status of females and males on site. Women have less possibilities to affect change in or resist their conditions of work because of social norms and their social ties. Women often get shorter contracts and less working days in a month than men. Not only are women located in the bottom of the industry, they also have less opportunities to progress and promotion. (Barnabas et al., 2011, p. 226–230; Baruah, 2010, p. 41–42; Bhattacharyya & Korinek, 2007; Khurana, 2017, p. 922–928.)

Living conditions and health in the construction sector

The casual, unorganized and flexible nature of construction work leaves the workers vulnerable and often without benefits or services, even though the construction sector is prone to accidents. The rights of workers are minimal as their position is strongly subordinate compared to the contactors or employers who often delay payments and can stop employing the workers. (Bhattacharyya & Korinek, 2007.) The exclusion of workers in the informal sector from social services is a global phenomenon that creates a great burden to many countries (International Labour Office, 2018, p. 55). The Indian social security system is also largely built for workers in formal employment (Dhas & Helen, 2008). The migrant workforce is attractive to employers as it means less, if any, obligations for employers and the possibility to pay very low wages (Deshingkar & Akter, 2009, p. 28).

Premchander *et al*. (2014) have studied the situation of migrant construction workers in Bangalore, the capital of Karnataka. Bangalore has experienced rapid growth in the IT-sector which has created demand for construction work to facilitate the increasing number of IT-sector employees. This explains the large number of migrant workers from other states working in Karnataka. (Premchander

et al., 2014, p. 115.) Even if migrant workers in the construction sector were paid well, they lacked access to basic services and satisfactory living conditions. None of the workers participating in the research by Premchander *et al.* had health or life insurance. (ibid., p. 113.) Many workers do not have proper housing with sanitation facilities or clean water, but they have to stay in tents or sheds on the construction sites or on the roadside (see e.g. Barnabas et al., 2011, p. 223–224; Premchander et al., 2014). The living conditions put them on high risk of diseases for example from mosquitoes or dirty water (Bhattacharyya & Korinek, 2007, p. 523; Premchander et al., 2014, p. 123–124). Living in harsh conditions makes the migrant construction workers very vulnerable to health-related risks, which highlights the need for provision of health services.

2.3 Profile of internal migrants working in construction in Manipal

All construction workers interviewed for this study were employed through informal arrangements. During the data collection process, I identified three different groups, in which I categorized workers based on the level of informality of their employment. The group with the highest level of informality in their employment consisted of intra-state migrants from Northern Karnataka. They usually earned less than 10 000 rupees[1] a month and did not have certainty of work being available; many mentioned that they work three or four days a week depending on the need of the employer, who were small local contractors. This group of people did not have any social benefits from their employer and even the treatment of workplace injuries was not covered by the contractor, or the workers were unaware of whether it would be covered. This group had spent very long times in the area, some even decades, and they typically lived with family members. They also visited their home places more frequently compared to other workers and spent longer times there.

The other two group of workers were dominantly male and worked more often as so-called skilled laborers. They had come from other states in North India to work and mostly left their families behind. They worked for large contractors that managed multiple construction sites nationally. Unlike the first group, the other two groups did not pay for their own housing, but it was provided by the constructor. They were also given other benefits, such as coverage for injuries happening on the work site. Characteristic to the second group was that they were not sure about the responsibilities of their

[1] 130 euros (9 June 2019)

employer in cases of injury or sickness or that workers working in similar roles for the same contractor had differing information about those responsibilities. The third group with the lowest level of informality, or rather highest level of formality, were provided a lot of information about health and close-by health care facilities. Their contractor also covered some non-work-related medical costs. As long as they did the morning entry they were also paid for their sick days off work. The division between skilled and semi-skilled laborers does not fully capture the diversity of the group interviewed, but broadly speaking the group whose employment was the most informal could be characterized as semi-skilled, and the majority of the two other groups as skilled laborers.

3. Access to health care

Health care provision can be seen as a core social institution of society. Health being a fundamental human right, providing access to health care is essential for all societies as access to health care is needed for people to maintain or improve their health. Health care provision reflects the norms and values of a given society and can both create and diminish equality and dignity. (Gulliford et al., 2002; Yamin, 2016, p. 104–105.) Access to health care is one of the central concepts of right to health and universal health coverage, both of which have been recognized by the Government of India (Balarajan, Selvaraj, & Subramanian, 2011; Gulliford et al., 2002).

Access to health care is a complex concept which has been described, explained and conceptualized in many different ways. In their review of literature in access to health care, Levesque, Harris and Russell (2013) found that there is no shared understanding of the concept. This chapter unwraps the concept of access to health care in its many forms. It also explores the current context of health care access in India, and among internal migrant workers in particular. At the end of the chapter, I present a theoretical framework used in the analysis of this study, the health care access barriers model, giving a foundation for this study.

3.1 Access to health care: a complex concept

The narrowest interpretation of access to health care is service availability. It is usually measured based on numbers such as doctors and hospital beds per area or per capita as well as costs of health care (Gulliford et al., 2002, p. 186–187). This approach is very limited and does not cover the real possibility of a person to use services.

Another widely noted dimension of access to health care is financial accessibility. Poor health and poverty can be seen as being in a two-way relationship where each affects and strengthens the other. Poverty creates financial barriers in access to health, and poor health can drive people to poverty due to the financial burden it sets on them. Poverty is also interlinked to other aspects of access than financial accessibility especially in low- and middle-income countries (LMICs). Geographical

accessibility is at risk due to poor infrastructure and transportation facilities in poor parts of countries, which doesn't only affect the access of patients to the facilities but also the reach of medication and other supplies to the facilities, undermining the quality of care. (Peters et al., 2008.) Poor people do not have the resources such as time off work to overcome barriers to availability, for example long waiting times and lack of proper medication, while more well-off people can use their resources and choose service providers more freely to avoid these barriers (ibid.).

Availability of services and financial accessibility, albeit important, are not the only dimensions that need to be evaluated in research on access to health care. Access, in its entirety, "*implies that individuals recognise and accept their need for services, consent to a role as service user, and acknowledge socially generated resources that they are willing to utilise"* (Gulliford et al., 2002, p. 186–187).

For example, Peters *et al.* (2008) offer a concrete model of access to health care, which includes geographical accessibility, availability (in terms of both hours of operation and provision of the right kind of service), financial accessibility and acceptability. All of these are also tied to the quality of service. (ibid.) Gulliford *et al*. have also identified different dimensions of access to health care in addition to service availability and financial barriers, many of which overlap with the previous model. There can be organizational barriers in the operations of the service system that deny the access to health care. (Gulliford et al., 2002, p. 187.) For example, a federal system can create management-related challenges in access to care (Brown, 2009). Also relevance and effectiveness, that is obtaining the right kind of health care, can be seen as an aspect of access (Gulliford et al., 2002, p. 187). Access can also be assessed based on equity; proper access to health care requires that different groups have similar access to care when they have similar needs for it (ibid., p. 188). This last point of equity between groups directs the discussion on access to health care services to social policy-oriented look on equality.

Even broader and more complex conceptualization of access to health care is offered by Levesque *et al* (2013). This patient-centered model covers the whole process of health care seeking, starting from the perceptions of need for care. The five aspects of access to health care included in the model are approachability, acceptability, availability and accommodation, affordability and appropriateness. While being separate concepts, all of these are also interconnected. Levesque *et al*. suggest that they

can be turned into abilities; ability to pay, ability to seek care and so forth. These "five A's" can be shortly summarized as the following:

Approachability includes the knowledge of services being available and the belief that approaching these services can be beneficial for a given medical condition. *Acceptability* is the possibility of people seeking care to see the service as socially, culturally and personally appropriate. *Availability and accommodation* cover the question of how easily the service can be reached physically and in what time, and how these can be combined with personal characteristics, such as type of employment. *Affordability* covers both direct payments of service and financial aspects related to it, such as loss of income. *Appropriateness* answers the question of whether the care, the way in which and the time at which it is provided fit the need of the patient. (Levesque et al., 2013.)

The model introduced last incorporates two important sides of access: demand and supply side factors. Access is often seen as a combination of the characteristics of the services – location and time of operation, quality of care, availability of medicine and so forth – which constitute the supply side. However, also the characteristics of patients and the public, in other words the demand side, shape access to health care. (Levesque et al., 2013.) For example, type of employment and exposure to information about health services affect the access of an individual to said services.

Later in this chapter, I introduce the health care access barriers model (HCAB), which I use as the theoretical framework in this study. It is created by Carrillo *et al.,* (2011) and is based on a review of multiple models of access to health care. During data analysis, I found the HCAB-model to explain well the different aspects of the data; financial, cognitive and structural barriers in access to health care. Additionally, the HCAB-model allows for the examination of both supply and demand side factors of access within its view of different kinds of barriers to care. Before presenting the HCAB model, I next offer an overview of the Indian health care system and access to health care in India.

3.2 Overview of Indian health care services

The overall provision of health care services in India comprises of a complex network of public and private facilities and service providers. The responsibility of public health care provision in India

mostly lies on state governments. The federal level is responsible for national health policy and international treaties as well as regulation, national disease control, family planning programs and medical education, while the states have responsibility for the organization and delivery of services. (Gupta & Bhatia, n.d.)

About a third of public spending on health comes from the central government, the rest being the responsibility of the states. The per capita health expenditure of states varies significantly, differences being as much as tenfold. Among 14 major states, Karnataka ranks as tenth and on a national ranking its per capita health expenditure is slightly below the average. Compared to the states where the inter-state migrants who participated in this study come from, Odisha, Bihar and West Bengal, the per capita health spending of Karnataka is higher. Although Karnataka ranks as third in the total number of registered doctors, its score for population per government allopathic doctor is above the average. This means that although the overall number of doctors is high, government doctors in Karnataka have to serve more people than the average government doctor in the country. (Central Bureau of Health Intelligence, 2018, p. 177; p. 217 –221.)

All public health services are available to all citizens in principle, and an extensive selection of services, including preventive and primary care, diagnostic services, and outpatient and inpatient hospital care are provided free of charge. However, there are bottlenecks and challenges that undermine their factual availability to all (Gupta & Bhatia, n.d.), which are explored in more detail in the next sections. The use of private health services in India is very high. Approximately 70 to 75 percent of morbidities were treated in private facilities in 2004, and the rate has remained at around 75 percent also in later studies. People with lower income rely more on public care, as do rural dwellers. (Desai, Vanneman, & National Council of Applied Economic Research, 2005; Ministry of Statistics and Programme Implementation, 2015, p. 15–17.) Despite the dominance of the private sector, there is very limited uptake on private health insurance, and most of the payments are made at the point of service (Gupta & Bhatia, n.d.).

The private health sector consists of a variety of facilities and providers, ranging from individual practitioners or small nursing homes to large specialized hospitals. Commonly and in the context of this study, the private sector is seen as the combination of both for-profit and non-profit arrangements, the latter including health facilities ran by charities, religious organizations and other voluntary organizations. The private sector, thus, includes all services that are not ran and financed by the

central or state governments or local public bodies. The very high utilization rate of private health services is not directly connected to better performance compared to public counterparts. The private sector is poorly regulated and unqualified and incompetent doctors and other health workers are very common also in the private sector. (Barik & Desai, 2014; Gupta & Bhatia, n.d.)

The guidelines for public health care service provision in rural and urban areas differ, but both follow a three-tier system. In rural areas primary care is provided in subcenters and primary health centers and secondary care in community health centers. It is followed by district hospitals as the providers of tertiary-level care. (Chokshi et al., 2016.) In urban areas, primary care is provided by accredited social health activists (ASHAs), auxiliary nursing midwives and urban primary health centers, and secondary and tertiary care in urban health centers and district hospitals, respectively. All of the different facilities cater to a set number and profile of population, increasing step-by-step from subcenters and ASHAs to district hospitals. Each type of facility also has a set standard of different health care professionals and equipment, both of which, however, often don't make it from recommendation to reality. (Chokshi et al., 2016; Gupta & Bhatia, n.d.) There is one Urban Primary Health Centre in Manipal and another one elsewhere in Udupi. The Urban Primary Health Centre provides primary health care services for everyone residing in the area. Services as well as medication are provided free of charge. There is also a District Hospital in Udupi.

Before exploring the issues relating to health care access in India, it is important to highlight one major reason for the non-realization of equal access to health care. Although public spending on health care in India has increased both in terms of absolute spending and percentage of GDP (Central Bureau of Health Intelligence, 2018, p. 172), public spending on health is still very low. Public expenditure on health as percentage of GDP is 1,28%, which is very low compared to other countries. India is among the 10 countries with the lowest percentage of all government (central and state) spending allocated to health, and its per capita health spending is among the lowest in the world. (World Health Organization, Country Office for India, 2012, p. 9–10.) These figures provide a background for understanding especially the issues relating to service availability and costs, even though low health spending does not explain the whole picture.

3.3 Access to health care in India

The challenges regarding access to health care found in India are very reflective of the theoretical explanations on the topic. Reports by Indian institutions and external organizations as well as academic research draw a complex picture of different factors that challenge the realization of access to health care. It is reflective of other social determinants in India. Those who are in a vulnerable position in the society due to, for example, their economic status or gender, have poorer access to health care (Levesque, Haddad, Narayana, & Fournier, 2006, p. 278). In its last five-year plan, the Planning Committee of the Government of India identified five weaknesses of the Indian health care system: availability of services is inadequate; quality of services is varying and not well regulated; affordability is problematic and out-of-pocket costs high; demands for care are increasing with rising life-expectancy and awareness of the public; and fifth, government expenditure on health is very low (Planning Commission of India, 2011, p. 2–3). Even where appropriate Acts are in place, implementation suffers from structural issues and lack of data (Carg, 2014, p. 243–246). All of these weaknesses directly hinder people's access to health services. In this section I also use data on utilization of health services to describe the topic. Although use and access are not the same thing, patterns of utilization of health services give some clues about people's access to said services.

The price of health services is well known to hinder Indians' access to health care. Price is one of the top reasons for non-utilization of health services. As can be expected, it is a more important factor for people from low-income backgrounds. (Ager & Pepper, 2005; Arokiasamy & Pradhan, 2013; Borah, 2006, p. 928; Kundu, 2010; Levesque et al., 2006; Mohindra, Narayana, & Haddad, 2010.) More than a fifth of Indians report borrowings as their major source of expenditure on hospitalization, the percentage being somewhat lower among the highest income quintiles (Central Bureau of Health Intelligence, 2018, p. 182). This comes as no surprise since out-of-pocket (OOP) expenditure in health is very high in India (World Health Organization, Country Office for India, 2012, p. 10). In fact, OOP expenditure counts as 65% of all health expenditure, compared to an international average of 44% (Central Bureau of Health Intelligence, 2018; Xu et al., 2018, p. 7). In 2004, poor households spent an average of 14,5 percent of their monthly income on health (Desai, Vanneman, & National Council of Applied Economic Research, 2005). Furthermore, the cost of health care has risen in the previous years, which further weakens access to health care (Central Bureau of Health Intelligence, 2018, p. XV). Reducing out-of-pocket expenditure on health by increasing government expenditure on health is a recognized way to enhance access to health care (Ministry of Health and Family Welfare, 2017; NITI Aayog, 2017, p. 144–151). High costs make access a socio-economic question, as the economic

status of an individual is connected to their social status in India (Borooah, 2005; Levesque et al., 2006). Overall, access to health services is lower among the lowest strata of the society (Arokiasamy & Pradhan, 2013; Srivastava & McGuire, 2016).

The availability of services is challenged by a lack of facilities and health care professionals as well as their uneven geographical distribution. Physical accessibility, as in the proximity of or distance to a health care facility, is a significant element of (non-)utilization of health care services in India (Ager & Pepper, 2005; Arokiasamy & Pradhan, 2013; Borah, 2006, p. 925). There is an extensive lack of facilities which creates a significant supply-side barrier. Human resources for health are also lacking and the shortage of trained health care professionals is a major challenge for Indian health care provision (World Health Organization, Country Office for India, 2012, p. 12–14). Especially primary health care is in need of more professionals (Planning Commission of India, 2011, p. 147).

The availability of services, in terms of both distance and staff, varies across the country. There are less services available in the least developed northern states and the existing human resources are unevenly distributed inside the country. The difference in the availability of health care services between urban and rural areas is high; for example, while 68% of Indians live in rural areas, more than 60% of hospital beds are in urban areas. (Central Bureau of Health Intelligence, 2018, p. XV; Ministry of Health and Family Welfare, 2013, p. 1.) The availability of services nearby is a stronger determinant of use for rural dwellers compared to those living in urban areas (Arokiasamy & Pradhan, 2013; Kundu, 2010; Planning Commission of India, 2011, p. 143).

The lack of health care professionals affects another factor of health care access, the quality of services. Lack of quality acts as a barrier to service use in the country (Kundu, 2010; Mohindra et al., 2010). In addition to the lack of trained staff, quality issues include the lack of equipment or medicine (NITI Aayog, 2017, p. 144–151; World Health Organization, Country Office for India, 2012, p. 13–14). For a patient, quality can be a more important factor of access and utilization than easy physical access: Ager and Pepper found that in the villages they studied, quality concerns undermined the positive effect of geographical proximity as facilities in the village were not used due to experiences of poor performance (Ager & Pepper, 2005, p. 179–180).

On the demand-side, there are also social or cultural barriers in access to health care that especially hinder the access of females to care; the biology of men and women creates differing health problems

and needs, but gender also affects health and access to health care from a sociocultural aspect. Globally, India scored 147th out of 149 countries surveyed by the World Economic Forum in the gender gap in health and survival, consisting of the birth ratio (female/male) and healthy life expectancy measures. This speaks of issues in access to health care that are gender-specific. (World Economic Forum, 2018, p. 11–12.) Kundu (2010, p. 107) reports that nationally boys are taken to get health care more often than girls. Adult men also use health care services more than women (Srivastava & McGuire, 2016). There are also signs that men and women are starting to use and visit facilities approximately to the same extent and women can even use services more than men (Kastor & Shrestha, 2018). Nevertheless, the roles, responsibilities and access to resources of men and women affect their access to health care. Gender can also strengthen the effect of other barriers, as the analysis in this thesis demonstrates.

When access to health care seeking is seen as a full process that starts with approachability - the possibility of an individual to notice the need for health care - then information on health is an aspect of access. An important reason for non-utilization of health care services in the case of an ailment is that it is not considered serious (Arokiasamy & Pradhan, 2013; Kundu, 2010, p. 108). Unnecessariness is defined not only by individuals themselves, but also by family members. While not all ailments need medical care, this can also reflect a lack of information on health and on what should be considered serious. This view is supported by findings such as that public health services are used more among people who have at least primary education (Borah, 2006, p. 926) and that exposure to media increases utilization of health services (Arokiasamy & Pradhan, 2013, p. 386) – information and knowledge create demand.

Many of the factors that undermine access to health care in India have their roots in the way the health care system is run. Planning, managing, financing and regulating of the health care system create the conditions of access. To increase access to health care, these factors should be improved. For example, the absence of a tax-based financing system for health care creates challenges to service availability and the federal system makes management and regulation difficult. (Planning Commission of India, 2011, p. 10; World Health Organization, Country Office for India, 2012, p. 15–17.) In this study, the focus is on the barriers that individuals face when in need of health care. While important for the operation of the health care system, such structural challenges are not directly visible to the individual and therefore not explored in more detail in this study.

The factors challenging access to care examined in this section also apply to the group studied in this thesis. Next, I briefly examine how their position as internal migrant workers in the construction sector in an urban environment specifically hinders their access to care.

3.4 Access to health services among migrant workers in the informal sector

Social security was taken into account when the Indian constitution was drafted, but the different Acts incorporated into it were directed to either employees of the public sector or of organized private sector establishments, leaving informal workers largely out of the picture (Dhas & Helen, 2008). In addition to general challenges with health care provision in India, challenges to organize social security schemes arise from the fact that workers in the informal sector don't have long-lasting employer-employee relationships and their work is temporary and seasonal (Rajasekhar et al., 2008).

Migrants, both international and internal, face special challenges in terms of access to health services (World Health Organization, 2016). Lack of proof of identity and local residence exclude internal migrants from many social services as well as from amenities such as housing and bank accounts. Another challenge internal migrants face is living in multi-locational settings as the Indian social security system heavily builds on place of residence. (UNESCO & UNICEF, 2012.) Lack of language skills in the local language(s) and inability of the health care system to treat diseases endemic to other states can also create problems for migrant workers in need of health care (Akinola, Krishna, & Chetlapalli, 2014, p. 233). Internal migrants can also face a hostile environment as they are seen as a burden on the cities and are discriminated against based on their ethnicity, language and religion, which can hinder their access to health care (UNESCO, 2013, p.8-9).

There are myriad schemes and insurance programs regarding health, many of which are not national but state-specific. However, 86 percent of rural and 82 percent of urban population are not covered under any health care expenditure support scheme (Ministry of Statistics and Programme Implementation, 2014, p. 46). Thus, large sections of informal workers are without coverage or have very low coverage for sickness and injuries. The Employee State Insurance Scheme (ESIS) has been extended to also cover those working in the informal sector. It covers many, but not even nearly all informal sector workers as it is only applied in certain areas and in establishments with more than 10

employees. (Carg, 2014, p. 236–243.) Many of the programs and schemes are targeted directly at the poorest segments of the population or at women and children. (ibid, p. 237–239.) People in second and third income quintiles (counted from the bottom) often lack health insurance coverage as the public programs target those under the poverty line (the 1st quintile). Those in the second and third quintiles, however, easily drop down below the poverty line due to high out-of-pocket (OOP) costs related to health care. One of such schemes is the Rashtriya Swasthya Bima Yojana (RSBY) Health Insurance Scheme, which offers poor families a so-called below poverty-line (BPL) card, with which they can access many medical services for free. It has been established to support workers in the informal sector in particular, but it only targets households below the poverty line. ("Rashtriya swasthya", 2016.) This leaves many vulnerable workers out of its scope. Even if they are covered by a scheme, it usually only applies to in-patient care, not medicine or out-patient care (Carg, 2014, p. 241–242).

The internal migrants who are in the focus of this study reside in an urban area. The urban population faces different health needs compared to their rural counterparts, which are often connected to their hazardous and unhealthy working and living environments in the urban areas (Kumar, Sharma, Sood & Kumar, 2016). To accommodate the health needs of the growing urban population, The National Urban Health Mission (NUHM) was established in 2013. It is a sub-mission of the National Health Mission, together with the National Rural Health Mission. The NHUM targets the vulnerable sections of the urban population, including construction workers and temporary migrants. It ought to have universal coverage, set quality standards for service providers as well as quantitative standards for service provision based on town size. (Ministry of Health and Family Welfare, 2013.) The urban population increasingly faces the double burden of both infectious and non-communicable diseases. The density of population creates overcrowding of health facilities, which acts as a barrier to care and the NUHM also faces challenges in providing services at times and locations that are accessible to the urban working population. (Kumar et al., 2016.) Consequently, there is a large presence of private health care services providers in urban areas with a varying level of competence and qualifications (Ministry of Health and Family Welfare, 2013, p. 21–24).

3.5 Health care access barriers model as a theoretical framework

Next, I introduce the theoretical model that I use to analyze the barriers internal migrant workers face in Manipal, Karnataka. The health care access barriers (HCAB) model identifies three categories of health care access barriers: structural, financial and cognitive. All three categories are in a close relationship with each other. (Carrillo et al., 2011, p. 562.) The model can be used to analyze health disparities: the barriers can result in late presentation, decreased prevention and decreased care, which cause health outcome disparities (Carrillo et al., 2011, p. 565). The model has been used to identify health care access barriers facing, for example, the Roma community in Romania and non-camp Syrian refugees in Jordan (Ay, Arcos González, & Castro Delgado, 2016; George, Daniels, & Fioratou, 2018). The model is pictured in Figure 1.

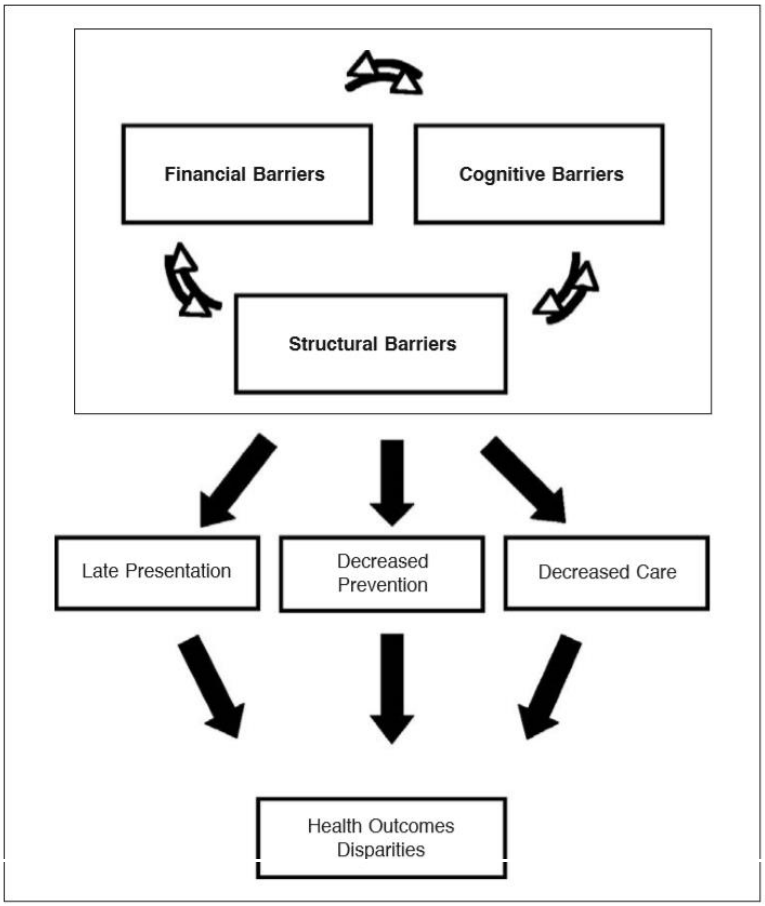

Figure 1 Health Care Access Barriers Model (Carrillo et al., 2011, p. 565)

The financial barriers to health care include costs related to doctor visits, test, treatments and medication as well as lack of health insurance. Structural barriers can be internal or external to the health care facility and include things such as availability of care and possibilities to reach it, as well as internal barriers within the service. Cognitive barriers are related to knowledge, understanding and

awareness of factors relating to health and health care. With such a taxonomy the model enables focusing on specific barriers, also the less evident ones. It can also be used to design community interventions. (Carrillo et al., 2011, p. 564–567.)

My analysis is focused on the upper part of the figure; the financial, cognitive and structural barriers and their relations to each other. This limited approach is caused by both the limitations set by the data I gathered as well as lack of a control group vis-à-vis which late presentation, decreased care, decreased prevention as well as overall health disparities could be identified. In addition, focusing on the barriers offers a possibility for social policy-oriented analysis and discussion.

In my analysis, I identified a fourth dimension that is in connection to the three sets of barriers; low trust in public health services. I will analyze this finding and its relation to the Health care access barriers model in depth in chapter 8. To provide a basis on which to build this new element of the model, I now move on to present the concept of trust and trust in public health care services in particular.

4. Trust in public health care

A major finding during the data collection process of this study was that among internal migrants working in the construction sector, there was a strong sentiment that public health care institutions are not as trustworthy as private ones. This finding offers a broader understanding of access to health care services and how trust is linked to it. To give the reader a foundation on which to assess my analysis, I explore the different theorizations of trust in this chapter, instead of leaving the topic to be fully covered as part of the analysis. In addition to a conceptualization of trust, this chapter displays reasons behind trust and factors that either produce or weaken trust in public services. A particular interest is in trust in public health care services.

4.1 Conceptualizations of trust

Trust as a day-to-day concept is easy to understand. It has also been theorized in multiple ways in a variety of disciplines. What draws together these theorizations is an understanding that trust requires that the truster believes the motivations of the other person or institution are for his or her best interest and therefore sees it reasonable to put their trust on them. (Hall et al., 2001, p. 616.) In a trust relationship the truster has positive expectations about both the competence and the intentions of the trustee - intentions are therefore as important as actual results of an act (Calnan & Rowe, 2007, p. 284; Hall et al., 2001).

In addition to a positive perception of the other party's intentions and skills, there are three more concepts that create a possibility for trust to exist; vulnerability, dependency and risk. Trust only occurs where there is a risk of something negative or unwanted, otherwise a person would not have to make a calculation of the trustworthiness of the other. There is also no need for trust without vulnerability - a possibility that the risk taken causes negative consequences (Calnan & Rowe, 2006, p. 349; Hall et al., 2001, p. 615.) For there to be an aspect of vulnerability present in the situation, there must be at least some degree of dependency between the parties (Klijn & Eshuis, 2013, p. 48). If one was not dependent on another person or institution at all and was not vulnerable to any risks in their relation to that person or institution, trust as theorized here would not exist.

Trust is closely linked to confidence and satisfaction, which are, however, distinct concepts. A situation in which confidence appears has less uncertainty than a situation of trust; the vulnerability needed for trust to exist is not present. As for satisfaction, it refers to an assessment of past events or situations, whereas trust is forward-looking. (Gilson, 2006, p. 361).

Trust can be broadly divided into two categories; a more personal and a more general, systemic trust. Uslaner calls these strategic trust in people we know and moralistic trust in people we don't know, and who likely are different from us. He also makes a distinction between generalized and particularized trust, where the former is trust in other people in general and the latter is trust in one's own in-group. (Uslaner, 2000, p. 571–573.) Pearson and Raeke distinguish between inter-personal trust and social trust. The former is grounded on repetitive interactions with a person, whereas the latter is trust in social institutions based on general information and views of the institution. (Pearson & Raeke, 2000.)

Trust happens and grows in interaction. Therefore, it can also be indirectly managed. (Klijn & Eshuis, 2013, p. 52.) This is an important remark for the understanding of trust in this study; if willing to, service providers are able to create conditions in which trust can come about and grow. Trust can and must be managed through, for-example decision-making practices and communication (Gilson, 2006). In the case of public health care systems, this requires actions from the management, not only from practitioners.

4.2 Trust in public services

As stated earlier about trust in general, trust is a mixture of trust in intentions and in competence. This is true also in the case of trust in public services, as *"[t]rust in government and public services assumes both commitment to such principles as honesty and reliability and certain levels of competence*" (Brookes, Mahon, & Llewellyn, 2013, p. 280).

Citizens generalize the information they have gained through different experiences with the government to make judgements on the trustworthiness of a public service (Greasley, 2013, p. 84–86). In addition to own experiences with services, the media and information from social networks

play an important role. The media becomes important especially when an individual is lacking first-hand experience of the service. Interaction in networks in which some trust exists creates knowledge about the government and public services. It can be easier to trust people you know and the knowledge they share than more abstract institutions (Llewellyn, Brookes, & Mahon, 2013, p. 13–17.)

Service performance is connected to the level of trust people have towards a service (Greasley, 2013). People are more likely to have an opinion on the quality of a service if it is one they interact with frequently (Manning & Guerrero, 2013, p. 113–117). However, improvements in the quality of service don't keep their glamour for long; improvements quickly become the new baseline for the service. Additionally, the effect of negative experiences is stronger than that of positive ones. Therefore, considerable improvement is needed for it to be noted by the public and avoiding bad experiences is more important than making good experiences even better. (Kampen, Van de Walle, Bouckaert, 2006; Manning & Guerrero, 2013, p. 112.) In addition, people's trust is not the same concerning all public services but differ from service to service, and the over-all trust in public services and the local government is strongly influenced by certain, so-called priority services that are most visible and known to the people (Manning & Guerrero, 2013, p. 116; Pollitt & Chambers, 2013, p. 52). Therefore, when trying to create more positive views of public services in general, improvements in quality should happen in these well-known services to have the biggest influence.

According to a study by Manning and Guerrero in the city of Medellin in Colombia, trust in public institutions is formed more by perceived performance than actual current service delivery (Manning & Guerrero, 2013, p. 116–117). When the quality of a public service varies, people are likely to judge the quality as poor. This happens even if their own experiences are positive, as the experiences of their social networks play a role in an individual's opinion-making. (ibid., p. 113–114.)

In addition to actual experiences on service performance, also information provided by the service provider on such performance can influence the level of trust. Information on the performance of the public sector can be seen as influencing citizens' more positive views on public services. This view has been, however, contested by Pollitt and Chambers who argue that it is unlikely that the public sector is able to produce information that is reached, understood and trusted by the citizens and contains information on performance that is higher than the public's expectations. (Pollitt & Chambers, 2013.)

Despite the fact that in this study the lack of trust in public services is seen as a barrier to health services and therefore has a negative connotation, it is important to briefly note that trust is not always thoroughly good. Trust in the government and public services can cause misuse of power as well as reluctance to change and development within the institution. A level of distrust can therefore sometimes be good to ensure the quality of services. (Connell & Mannion, 2006, p. 428; Gilson, 2006, p. 370.)

4.3 Trust in health care services

Because the health care system as an institution is trusted with important duties as well as personal information, it has moral obligations and must have ethical principles. Because of the possible dangers of trust briefly mentioned, trusting must be made possible and safe, focusing especially on marginalized groups (Gilson, 2006, p. 366). Trust is both intrinsically and instrumentally important in health care (Calnan & Rowe, 2006, p. 352). In its instrumental role trust enables effective quality care; trust in the health care system affects health outcomes, as people who trust the system more are more likely to seek help to their health problems and follow up on their treatment. (Hall et al., 2001; Mahon, 2013, p. 215.) For example, Lucy Gilson points out that low levels of trust in health services can influence lower use of health services among disadvantaged groups in some low- and middle-income countries. Additionally, a trustworthy health care system can help to build up trust in the society more broadly and generalized trust in other people; thus, health care systems contribute to social justice. (Gilson, 2006, p. 361–362.)

Patient characteristics such as gender, education and health status have not been found to be strong determinants of trust in health care (Hall et al., 2001, p. 627–628). Trust is also not equal to the quality of care (Ozawa & Walker, 2011, p. 21). For example, no direct link between the performance of the health care system and public trust in the system was found in a study conducted in the Netherlands (van der Schee, Groenewegen, & Friele, 2006). Hall *et al*. (2001) have identified five dimensions of trust in physicians and medical institutions: fidelity, competence, honesty, confidentiality and global trust. Patient's trust and their experiences are in a cyclic relationship, where each affect the other; experiences can increase or reduce trust, and trust affects how experiences are perceived (Hall et al., 2001, p. 630).

Ozawa and Walker (2011) found that trust in providers was an important cause in decision making regarding where to seek medical treatment among Cambodian villagers. They found that trust in health practitioners overall was very high, and trust in public providers was somewhat higher that in private ones (Ozawa & Walker, 2011, p. 23–25). In their study about the National Health Service in England and Wales, Calnan and Rowe found that the two strongest determinants of the public's trust in the system were that patients are taken seriously and patients get enough attention (Calnan & Rowe, 2006, p. 354). In their study among diabetes and hypertension patients in Southern Karnataka, Aivalli *et al*. (2018) found that health care providers are chosen based on the trust and confidence on them. Their findings differed from those of Ozawa and Walker in that people in Karnataka preferred private facilities for acquiring health care despite their higher prices compared to government health facilities. Multiple aspects of trust in public health care services were identified. Some reasons for people to opt for private health services were confidence, loyalty to a (private) practitioner, the connection between expectations and experiences as well as communication and using techniques perceived as "higher quality". Also the views on the quality of medicine, among both patients as well as health workers, made the public trust private health care more, despite tests showing that the quality of generic, government provided medicine is equal to that of branded medicine. (Aivalli et al., 2018.) Other components of trust in health care, as reported from various low- and middle-income countries, are, for example, quality of training, ethical commitment, accountability mechanisms and drug availability (Gilson, 2006, p. 367).

As already stated about trust in general, trust is not created only through competent providers - motivations and ethical behavior are also needed. Interpersonal trust in health care professionals is a combination of personal relations and rapport between the patient and the professional and of information and evidence-based judgements. It is thus a mixture of confidence in their skills and competences and in their intentions to work in the favor of the patient (Calnan & Rowe, 2006; Gilson, 2006, p. 367; Mahon, 2013, p. 217). Health being a very personal and even emotional context of operation and the patient possibly being in a very vulnerable position, a personal trust-relationship between the patient and the doctor is important (Mahon, 2013, p. 209). Also the scientific knowledge needed in health care procedures sets the patient in a vulnerable position (Calnan & Rowe, 2007, p. 283). In order to trust the health care professional, a patient must accept their own vulnerability in the situation (Hall et al., 2001, p. 616). Judgements on competence are founded on personal experience as well as information from the networks and media, as discussed before.

Both interpersonal and institutional trust are or can be present at the same time in health care. A patient can trust or not trust both a specific health care professional as well as the system as a whole (Ozawa & Walker, 2011, p. 21.) Institutional trust has a different foundation than interpersonal trust in a practitioner. It is based less on personal experience and more on media portrayals, professional institutions and legal/regulatory protections (Mechanic, 1996; Goold, 1998). For example, payment mechanisms can create or limit trust in health care. Studies have found that payment mechanisms and treatment fees can be seen by patients as both signs of quality care and a way to get more personal attention, as well as signs of unnecessary costs and profit-seeking (Gilson, 2006, p. 367). Ozawa and Walker found that in Cambodia, interpersonal trust in certain practitioners was more important than institutional trust in the system. Health care providers in different sectors were trusted for different reasons. Public health care providers were trusted for honesty, good morals and skills whereas private practitioners were trusted because of interpersonal relations, carefulness and practical reasons (Ozawa & Walker, 2011, p. 23–26).

Calnan and Rowe (2007) distinguish between informed and embodied trust of a patient. The former is based on information, including on the competence of the practitioner as well as on the patient's own information that they can use in the role of an active participant. Informed trust makes the patient more calculative on their trust relationship. Embodied trust, on the other hand, is based on a more traditional power-relation between the patient and the practitioner and can be more emotion-based than informed trust. (Calnan & Rowe, 2007, p. 296.)

In health care, a lowering level of trust in doctors can be seen as a cause of societal processes, such as greater availability of information, the rise of consumerism, marketization of health care and the rising emphasis on self-care and decreasing trust in authority (Calnan & Rowe, 2007, p. 289; Mahon, 2013, p. 207–208). A focus on the empowerment of patients and their active participation in decision making and in their treatment may be contradictory to the creation of trust between the patient and the health care professional as it changes the traditional truster-trustee-relationship in health care (Calnan & Rowe, 2007, p. 288). Trust relations between the patient and the service provider can also be influenced by the trust relations between providers and providers and managers (Calnan & Rowe, 2006, p. 350). In order to increase trust in the health care system in low- and middle-income countries, Gilson argues it would be important to develop provider-manager relationships, because these can affect the way patients are treated and therefore how they perceive the system (Gilson, 2006, p. 368–

369). Aivalli *et al.* (2018, p. 10) argue that the lack of proper regulation from the government can act as a driver for people to seek care in the private sector, as it reduces their trust in the public system.

In conclusion, trust in public health care services is created in interaction and can be interpersonal or institutional. It is based on personal experiences, assessment of competence and skills as well as knowledge shared in formal and informal networks. Trust affects decision making regarding health care and is therefore an important component of health care access. In the next chapter I present the methodological foundation of this study, before a deeper analysis of health care access and trust in the following chapters.

5. Study design

Statistical generalization is usually not the goal of qualitative research. Instead, it focuses on providing a deep understanding on a phenomenon. (Tuomi & Sarajärvi, 2018.) Access to health care is a multidimensional concept, so even with a sophisticated model measuring access is difficult (Levesque et al., 2013, p. 8). Hence, choosing a qualitative approach was justified as the aim of this case study is to produce sensitive knowledge on the complex experiences of the participants. In this chapter I give an overview of the research process. I start by presenting my research question and continue by describing the data as well as the method of collecting and analyzing it: semi-structured focused interviews and theory-guided content analysis. At the end of the chapter, I reflect on the ethical factors of this study, in particular on my role as a foreign researcher.

5.1 Research question

In the beginning of this research process my interest was very broad and it stretched to cover a variety of questions around health and health care service use. When learning more about the previous studies done on this topic and especially during the data collection, it became clear that the focus would be on access to care. When collecting and analyzing the data, I found that the differences between genders, inter- and intra-state migrants and the informality of work were not as strong factors as I had anticipated them to be. Thus, these were no longer the main focus of the study, although they are discussed as part of the analysis. This change in direction was supported with the finding of the HCAB-model which, with data-based modifications, supported well the analysis of the data.

On the basis of previous studies and the data I had collected in Karnataka, the research question developed into the following:

What kind of barriers do internal migrants working in the construction sector face in their access to health care?

The research question is supported by two further questions:

How are these barriers connected to each other?

What is the role of trust in public health care services in the context of access to health care?

To answer the research question, I use theory-guided content analysis to analyze fifteen interviews of construction workers which were conducted in Manipal in Karnataka, India. I use the previously presented health care access barriers model to present the findings of this case study and develop the model further.

5.2 Profile of internal migrant workers in Manipal

The data used for this research consist of 15 interviews with internal migrants working in the construction sector in the Manipal area of the city of Udupi in the state of Karnataka in South India. Out of the 15 interviewees, five were identified as female and ten as male. The age of interviewees ranged from eighteen to sixty-two. The length of stay in the area ranged from one month to thirty years. During data collection the target group evolved to fit the existing local conditions; the sample size and composition were re-defined, as is customary to qualitative research (Harris, 2015, p. 36–37). The original plan had been to interview both male and female inter-state migrants working in construction. During data collection it was found that there were no female inter-state migrants working at any of the construction sites in the area. Therefore, the scope of the research was expanded and also intra-state migrants from other districts of Karnataka were included in the sample to enable the inclusion of women in the research. Out of 15 interviewees, nine were inter-state migrants (all male) and six were from Karnataka (five females and one male). The inter-state migrants were from three states in the North-East of India; Bihar (5 people), Odisha (3 people) and West Bengal (1 person).

5.3 Semi-structured focused interviews

The data of this study has been collected using semi-structured focused interviews. A semi-structured interview, also called semi-standardized interview, is described as one that is not fully structured beforehand, as opposed to a structured interview. Instead, questions and their order may vary from one interview to another. The themes and topics of the interview are, however, the same for all interviewees and identified before the interview situations, unlike in non-structured interviews. (Ruusuvuori & Tiittula, 2005, p. 11–12.) The themes are based on the research question. For this study, the questions revolved around the following themes: experiences of health care services in current locality and in home place, decision making related to health care seeking, knowledge of services, availability and accessibility of health-related information and challenges relating to health care service use. The interview framework was developed together with staff and students of a local university to ensure its fit to the local context (see e.g. Rastas, 2005).

The method of collecting data chosen for a study affects what can be found out about the phenomenon (Rastas, 2005, p. 15). The main reason for the choice of semi-structured focused interviews as the data collection method for this study is that open-ended questions are used to capture lived experiences (Silverman, 2005). Interviewing, especially when using a semi-structured interview model, enables flexibility in the data collection in terms of specifications, clarifications, corrections and inclusion of new topics of interest. The flexibility and adaptability provided by this method of data collection was very important in this study, as the whole context was very new to me. I was able to develop the questions all throughout the process of data collection, which is a great advantage of qualitative data collection (Charmaz, 2006, p. 14). Using a semi-structured focused interview model allows for a more complex understanding of different barriers that affect the access to health services and the different occurrences of those barriers than a strictly structured interview would.

Interviewees produce and share knowledge in their role as informants in the interview interaction. They have the knowledge, information or experiences the researcher wants to find. Consequently, interviews are always interaction between more than one active party. (Ruusuvuori & Tiittula, 2005.) Conducting interviews also gave me as the researcher a possibility to familiarize myself better with the conditions and environment I am researching, even if my approach is not ethnographic. While recruiting participants and interviewing them I was able to make observations about work conditions, workers external characteristics, their living conditions and so forth. This would have not been

possible had I only used pre-collected or quantitative data or relied on someone else to conduct the interviews on my behalf. Furthermore, data collection in the form of surveys, diaries and other written forms would have heavily limited the scope of the study, as there were participants who were illiterate and many of those who were not able to read in English, Hindi or Kannada.

Conducting interviews

The interviews were conducted in January and February 2019 in Manipal, India. The interviewees were recruited from two construction sites and two residential areas where many internal migrant workers were known to reside. Recruitment was done "on the spot" and interviews were conducted immediately after. Two of the recruitment sites were visited on more than one day, so some interviewees may have thought about their decision to participate for a longer time. All interviews were conducted with the help of two local students who interpreted the discussion between English and Hindi or English and Kannada.

With a permission from the interviewee, all interviews except one were recorded. The recorded interviews were then transcribed into text. The interview which was not recorded was written down based on notes taken during the interview. Recording was a significant factor in the success of this study. Recording the interview gives an opportunity for a deeper analysis on what is being said as well as the context and way in which it has been said. It also gives the interviewer a possibility to fully concentrate on the discussion during the interview and better analyze their own role in the interview situation afterwards. (Ruusuvuori & Tiittula, 2005, 14-15.) I was very new to the environment and because of that and the translation, all my focus was needed to fully understand the answers of the interviewees. Note-taking would have made the interviews much less fluent, as happened with the non-recorded interview. In addition, recording provided me an opportunity to make clarifications and correct possible misunderstandings with the interpreters later. Making an effort to understand the experiences of participants is both a sign of respect and an urge for quality data (Charmaz, 2006, p. 19). Thriving for understanding ensures the findings of the researcher are" truer", despite the fact that findings are always interpreted by the researcher.

Semi-structured interviews work well in qualitative research, when the research question develops throughout the data collection analysis. Semi-structured interviews give room for such developments. While conducting interviews for this study, a high proportion of people told they prefer private health services over public ones. When this was taken up as a topic of discussion in later interviews, it started to seem like a major reason for using private services was low trust in public services. This was again brought to discussion in more detail with next interviewees. In this way the choice of data collection method allowed me to dig deeper into emerging themes.

According to Jouhki, the choice of the interpreter might affect who end up being interviewed because also the interpreter has a view of how the study should come about (Jouhki, 2006, p. 18–19). Thus, having two interpreters was a good choice for the randomness of the sample. In addition to their different language skills, the two interpreters were also able to encourage different kinds of people to participate in interviews. They had to take a lead in finding interviewees and explain what it means to participate. Many times they had to ask clarifying questions from the interviewee before translating to me to make sure the interpretation is correct and that way took an occasional lead of the interview. Overall, the interpreters had a strong role in the carrying out of the interviews.

During data collection we encountered situations were either my question was not clear for the interpreters, they couldn't find a way to translate it, the interviewee didn't understand the question or the interpreters didn't understand the response. This affected the data and is a limit to this study. Most of the time such problems could be overcome or they were disregarded, like in the following insert. We were able to avoid such bad uncertainty which would challenge the ethicality of the study or which would create frustration that strongly influences the interview situation (Rastas, 2005).

> *M[2]: Okay. Eeh, well does he have any suggestions, what could be better?*
>
> *[discussion in Hindi]*
>
> *H: I think I'm not able to, you know, explain the question very properly to him, so he's saying like there is no such suggestion that he has got*

[2] M: interviewer; H: interpreter; S: interpreter; R: interviewee

M: Okay

H: But I tried my best like twice. **(Male 26, Bihar)**

Some of the interviews conducted at the residential areas of the workers resembled focus group discussions. Interested family members and neighbors gathered around before and during the interview. This affected the interview situation in multiple ways, both negatively and positively. It is likely that interviewees were not as open about their experiences, especially about health problems or problems with the health care system, as they could have been had the interview been conducted more privately. On the other hand, this kind of consensus-seeking among other people who were in the same situation gives their views an even stronger foundation and these views can be treated as shared opinions of the larger group (Valtonen, 2005, p. 235). Additionally, in these interview situations also other people than the primary interviewee shared some of their experiences. These comments are not used as primary data in this study since consent for the use of them was not specified. Nevertheless, these opinions support the views given by interviewees and also provided myself with a broader understanding of the questions at hand.

During the whole data collection process I kept a field diary. I noted down my observations about the interviews, the interview sites and situations, as well as my thoughts, questions and some preliminary findings. I also discussed the topic of my thesis and their work in general with doctors and nurses at both private and public health institutions. In addition, I was able to discuss with a manager at one of the constructions sites in the area about the employment of internal migrants and employer responsibilities. These discussions gave me a good overview of the local situation and context in Manipal.

5.4 Qualitative content analysis

In this section I introduce the analysis method that I use in this research; theory-guided content analysis. I elaborate on how I use it to analyze the barriers in access to health care faced by internal migrant working in construction in India. I also briefly present how I used grounded theory as an

inspiration to revise the health care access barriers model to better explain the experiences of this group of people. I also give an overview of the analysis process.

Content analysis is a method of qualitative analysis that can be used for making sense of various kinds of qualitative data. It can be seen as both a method in itself as well as a broad umbrella concept of multiple qualitative methods. Content analysis can also be used quantitatively, but in this chapter I introduce the qualitative, more common, version of content analysis. (Tuomi & Sarajärvi, 2018, 103.)

After data collection and transcribing into text where necessary, the analysis process starts with narrowing down the focus of the research. This helps to dig deeper in to the question, providing meaningful insights into the phenomenon. When the question that is asked is clear, all elements in the data that are relevant to it are marked and coded. These marked contents of the data are then classified, categorized and sorted to draw together a comprehensive analysis. Depending on the tradition of content analysis, the number of times a certain theme is raised in the data may or may not be relevant. The main point of content analysis is to make sense of the data, and it can happen by searching for, for example, a common theme, similarities or differences, a logic of action or a typical storyline. The results of the study are, however, not the categories or themes in which the data has been assigned to. This is only the base on which conclusions, the actual results of study, can be made. (Graneheim & Lundman, 2004; Tuomi & Sarajärvi, 2018, p. 103–107.)

Content analysis can be divided into three distinct types: theory-driven, data-driven and theory-guided content analysis. Each of these have different premises on which the analysis is built. Data-driven content analysis aims at creating a theoretical view of the data without presupposed elements, based on only what emerges from the data. This type of content analysis is closest to grounded theory, which has also inspired the analysis, especially the revision of the HCAB model. Theory-driven content analysis, on the other hand, takes a very different approach. The analysis is based on a theory or a model - something that is already known from previous studies. This approach tests the given theory in a specific context or with specific data. (Eskola, 2018, p. 209-216; Tuomi & Sarajärvi, 2018, p. 103–111.)

The approach to content analysis I use in this study is theory-guided. It can be seen as borrowing elements from both theory-driven and data-driven content analysis. A theory or former knowledge on the phenomenon is used for analysis, but the theory does not limit the analysis to only its scope.

Rather, it supports the findings of the data and allows for a theoretical understanding. Data and theory are used in rotation to understand the phenomenon being studied. In other words, the data is not "forced" to fit a given theory, and the analysis is not limited to the boundaries of the theory or model. Instead, a theory is used to explain it where appropriate. Unlike in theory-driven content analysis, data collection is not formed around a given theoretical framework. (Eskola, 2018, p. 209–216; Tuomi & Sarajärvi, 2018, p. 109–111.)

I use theory-guided content analysis to analyze my data, working with the HCAB model. I create an extension of the HCAB model based on the data. This process, while done following the theory-guided content analysis tradition, was inspired by grounded theory. Grounded theory emphasizes the need of theory to be evidence-based, emerging from the data itself. This is facilitated by an ongoing analysis that starts during data collection, as well as theoretical sampling of participants. (Charmaz, 2006; Glaser, 1978.)

In grounded theory research, a theory is constructed through coding the data and creating categories of these codes (Charmaz, 2006, p. 6; Glaser, 1978; Glaser & Strauss, 1967). Sampling of participants is done on the grounds of findings from the data, in order to find data to strengthen or explain the categories and ensure their grounds. (Charmaz, 2006, p. 96.) Codes must be constantly checked with data. This process is called constant comparative analysis and its aim is to make sure the theory explains the phenomenon under study and is really based on the data. (Charmaz, 2006, p. 43–71; Glaser, 1978, p. 4; Glaser & Strauss, 1967.)

The diverse sample of interviewees, careful coding and thorough reasoning of the analysis were all means to ensure the credibility of the study (Graneheim & Lundman, 2004, p. 109–110). Nevertheless, no method of analysis can be free from presuppositions. These are posed by the choice of research question and perspective as well as the knowledge and biases of the researcher (Graneheim & Lundman, 2004, p. 106; Tuomi & Sarajärvi, 2018, p. 109). Preconceptions arising from the researcher's own position and background influence the coding process, the way in which the researcher interprets what is being said, as nothing emerges from the data without the active analysis of the researcher (Charmaz, 2006, p. 67; Eskola, 2018, p. 210). So, while ”data speaks”, the way I hear it and note it down is likely to be different from the way someone else would hear it. Next, I elaborate on how I carried through this process.

5.5 The analysis process

After transcribing the data, I started coding and labeling all excerpts of the data that were somehow linked to my preliminary research questions. I organized different findings to make sense of different patterns within the data. This phase was done as per the typical style in theory-guided content analysis and grounded research, that is the codes and their connections were not based on theory but emerged from the data. While the analysis process was still ongoing, I went back and forth between the data and theoretical as well as practical writings on access to health care, as is typical for theory-guided content analysis. I found the health care access barriers model to be very descriptive of the findings from the data and decided to use it as a tool to analyze the experiences of the interviewees. At this point, the research question formed into one that regards barriers in particular. I used the HCAB model as a supportive tool in my analysis of structural, financial and cognitive barriers. This is presented in chapter 7.

Theory-guided content analysis allows for findings which either undermine the model or don't fit the model as such. Hence, another element emerging purely from the data, lack of trust in public health services, was found. While the other three categories were further developed based on the HCAB model, distrust in public health services was an addition to the model. I worked on the analysis of low trust in public services based on what was said by the interviewees before familiarizing myself with the theoretical foundations of trust in public health services. When my findings on trust in public health services were formed, I combined them with theoretical findings on the topic to develop my view on the matter, as presented in chapter 8. In this way, the HCAB model did not only guide my analysis, but itself got developed during the process.

5.6 Ethical considerations

All participants were provided with a detailed explanation of the study and the use of their information and they signed an informed consent form with which they allowed the use of their information. They were also given a phone number which they could contact in case they wanted to withdraw from the

study after the interview. All data has been coded and used anonymously and neither individual participants nor health care practitioners can be identified. Confidentiality between myself, the interpreters and the interviewees was strongly highlighted because of the sensitive nature of health-related questions. The participant information sheet and the informed consent form can be found as appendices 1 and 2.

Many participants of the study were not familiar with health care facilities available to them in the area. Taking into consideration this lack of knowledge and the vulnerable position the workers were in, a decision was made to tell them about the local Urban Primary Health Centre. Information on its location and services were provided after every interview, unless the participant clearly demonstrated knowledge of the center. Some interviewees and other people present wanted medical advice. This was not given and they were encouraged to contact a health professional.

As a Finn in India

The major ethical considerations of this study should be given to the setting in which I, a master's degree student from Finland, interview Indian internal migrants and do the research on an Indian issue. My prior knowledge of life in India was very limited. I had only travelled to the country once and the Indians I had met before my research trip have all been quite well-educated people participating in various international events. In addition, India itself is a multicultural society with a myriad ethnic groups and languages, topped with the caste system. Therefore, special attention was needed both during data collection and later during the analysis to notice how this affects the study, its ethicality and its reliability. To prepare myself before data collection, I acquainted myself with the experiences of other Finns and other Northern Europeans who have done research in India by reading their texts and discussing in person (Foulkes Savinett, 2015; Jouhki, 2006; Korpela, 2009; Ranta-Tyrkkö, 2010).

There are always differences between the interviewer and the interviewee. Most of the discussions around the relations of the researcher and the subjects of the study have happened in the area of anthropology (Rastas, 2005). In the case of this research the differences are very clear and vocal: cultural and ethnic background, economic status, language. I clearly come from a position of power compared to the participants of the research. Multiple interviewees mentioned that they think they

are not knowledgeable enough to speak about the development of the health care system, making visible the position me and the interpreters had as “experts”.

Cultural differences can be understood as differences in lived experiences, thinking and the ways in which one makes sense of the world (Huttunen, 2002, p. 125; Rastas, 2005). It is important to not see a group or individual as more 'cultural' than another – for example myself. I am also a cultural subject, not a neutral actor. According to Huttunen, it is typical that the 'farther away' from the researcher the culture that is being discussed is, the more it is seen as a solid and coherent concept that has a strong power over its members. Contrary to this, the researcher's 'own' culture is more likely to be seen as nuanced and not as determinant to the people under its influence. (Huttunen, 2002, p. 125; Rastas, 2005.)

It is impossible to know a culture thoroughly. Instead, I acknowledge the limits of my own cultural understanding. It is also important to acknowledge that ideas of culture have been created before the interview situation (Tienari, Vaara, & Meriläinen, 2005). The information shared during the interviews must be evaluated against the situation in which it was collected (Oinas, 2004, p. 220–221). We all have our own perspective stemming from our background and experiences. How I and my intentions were interpreted by the participants also influenced what kind of information I was given. (Ranta-Tyrkkö, 2010.)

Interviews can only be successful if the interviewer and the interviewee understand each other. Living in different cultural contexts may hinder the possibility of the two to understand each other (Rastas, 2005). For this, it was vital that the interpreters were locals who were able to not only translate the language but also cultural meanings and point out to me things I otherwise would have left unnoticed.

In contrast to differences, also togetherness between the interviewee and the interviewer can arise from many different characteristics (Tienari et al., 2005). Before the data collection process, I anticipated that gender and age can be such factors and that they can alleviate the obvious power-imbalance. Reflecting back, my relatively young age didn’t seem to influence the interview situations, but I feel like being female helped me to gain the trust of some women. However, as only the interpreters were able to be in direct verbal contact with the interviewees and thus lead the process of recruiting, their characteristics (male/female, local/not local, well-educated) seemed to be more important than mine.

The exercise of power is not limited to the interview situation. Also the ways in which the interviews are described in the research text, what kind of language is used and what citations are chosen is an exercise of power. (Oinas, 2004, p. 217.) 'Culture' should not be the only explanation of differences because a culture is not stable but something that is constantly contested by differing views within its framework (Huttunen, 2005, p. 134). Seeing culture as the only explanation may hinder understanding of the differences caused by, for example, age, gender and socio-economic status. All these characteristics are context-based and together create meanings and experiences. I have tried my best to acknowledge my biases and presuppositions that affect the way in which I conduct this research. This is a reason why I, for example, don't want to make far-reaching assumptions about some of the social sources of distrust in public services; I believe a different study setting would be needed for me to acquire knowledge on such societal forces in the South Indian context.

6. Insights into health care access barriers

In this chapter I analyze the barriers internal migrants working in construction sites face using the health care access barriers model. All three categories of barriers - financial, cognitive and structural - were represented in the data in several ways. However, the barriers were not very evident in the case of all workers. Even where they were taken note of and recalled, they were not seen as great hindrance by all – surprisingly many workers saw their overall access to health care as satisfactory. This does not, however, diminish the importance of the barriers. The fact that they were considered by the interviewees proves that they are not insignificant. Moreover, the barriers in access to health care seem to follow social determinants in the society; challenges are related to factors such as income, gender, type of employment and migration. This chapter draws a picture where structural, financial and cognitive barriers are connected to each other, creating a network of barriers to this group of people in a vulnerable position.

6.1 Financial barriers

The key component of financial barriers in the health care access barriers model is the cost of health care. Contrary to a consensus among those writing on the topic, for many workers the costs of health care were not a notable barrier to care. The costs were seen as reasonable and health as a cause important enough to invest in. This view was supported in the case of both services as well as medication.

However, costs were mentioned by some workers and for them, it appeared to be a major challenge. Not surprisingly, the price of health care was a barrier especially to those whose earnings were lower. Some had even taken loans to cover their health care costs. Whether the cost of health care was seen as a barrier was also indirectly linked to the level of informality of employment and gender; those in more informal employment settings as well as all women earned less and, therefore, the price of health services make up a larger portion of their income. The two women whose quotes are presented below earned notably less than men working in the same site as them, as women were only given work in assisting roles. One of them was unable to take her daughter to get the health care she needed.

The family was indebted due to her husband's medical costs and her contractor didn't have enough work for her to make an income that would cover the costs related to her daughter's health care.

> *S: Presently when her daughter is, you know, eeh… complaining about, headache and all those things since last six months and today she was supposed to go for scanning but they didn't go. […] And… they are already indebted because of the husband… and to avail the scanning it's like very difficult for her […] She missed the school because of that and they don't have money to pay for scanning.* **(Female 30, Karnataka)**

> *S: She feels that even if government hospitals for certain cases they take money. Like for surgeries and other things even that price should be reduced because some seventy thousand[3] for her was like, a huge amount*
>
> *M: Okay*
>
> *S: For a person who earns three thousand rupees[4], per month.* **(Female 37, Karnataka)**

While the level of informality of employment affects the income of workers, it also creates or reduces other financial barriers to health care. Those in the least formal form of employment were not provided any financial help with health care by the contractor, while the two other groups were compensated for costs related to work injuries. The contractor in the most formal type of employment also paid for their workers' other medical or health related costs and provided free transportation to a health care facility when needed. These workers also told that they get paid for sick days as long as they enter the site in the morning, which was not possible for the others, or they were not aware of the possibility. Losing income as well as paying out of pocket for medical costs certainly creates different financial barriers than being more strongly supported by the contractor.

> *H: And I was like even though not like you were sick still they didn't give you, he was like no like if you're sick like if you're taking a leave for whatever reason you don't get paid and he's saying he's enrolled here on contract basis like it's not permanent so that is why he is not given these perks.* **(Male 60, Bihar)**

[3] 910 euros (9 June 2019)
[4] 39 euros (4 June 2019)

Many workers relied heavily on pharmacies for their health care. In particular, for things that were judged as minor conditions by the workers, such as fever, help was sought from pharmacies. As is, the cost of medicine was a big component of their health care spending. This is reflective of the situation of India as examined earlier, where the majority of out-of-pocket medical costs go to medicines (Planning Commission of India, 2011, p. 28). A similar pattern is found here than with health care costs in general; those with lower income found the cost of medicine too high.

6.2 Structural barriers

A typical structural barrier in the HCAB model is the distance to the health facility and working hours of health facilities (Carrillo et al. 2011, 567). Distance and transportation were barriers in access to public health services in particular, as the workers lived in an urban area where private facilities were also available to them. There was therefore not a general lack of services in their current locality, although it was noted as an issue in their home villages. Barriers relating to distance are closely linked to financial barriers, as acquiring the health care needed may result in missing salary.

> *S: It's like, to go to the government hospital in Udupi she has to take leave from the work and she has to go. But this [private practitioner] is closely, this is very proximate to this place also, so it is quite easy for her to go and... And going to [district hospital] she has to take every time like holiday and go so it is very problematic for her.* **(Female 30, Karnataka)**

Staff of the local government health facilities regularly conduct so-called health camps and visit the residential areas of migrant workers. This is an important part of their work in the urban setting. For some participants this was an important way to acquire basic services and get information about health. There were, however, structural barriers to access to this service in terms of timings of the field visits.

> *S: Okay she doesn't know anything much about anything, she doesn't get any information. I asked whether you get to know about, you get to know information*

through doctors or any government workers coming here, she said she doesn't know anybody because she goes to work and she won't be here. **(Female 35, Karnataka)**

The availability and accommodation aspect of access does not become realized when the conditions relating to employment and accommodation of the local population are not considered when services are implemented.

Some of the workers from Karnataka were eligible for a below poverty line (BPL) card issued by the State of Karnataka as part of the RSBY scheme. This allows them to acquire certain services for free or at a cheaper price. The BPL cards, however, at times caused challenges as they were registered at the migrants' home villages like was the case for these two women:

S: Yeah like some chronic illness happens where you know you need to get admitted, she don't have BPL card [here] so getting admitted to the government hospital is impossible

M: Mm yea

S: And even the test like all scanning, blood check-up, blood transfusion

M: Yea

S: All these things are expensive like if even in the government hospital if you don't have below poverty line card so, so… she had to go to the private practitioner. **(Female 30, Karnataka)**

S: She went to government hospital back home. Eeh, she possesses a ration card like below poverty line card so she went --

[indistinct speaking and background noises]

M: Can you ask her if that was the reason she went home, like to have the card or for some other reason?

[discussion in Kannada]

S: Yeah she went for that purpose itself. **(Female 23, Karnataka)**

As per the official guidelines of the RSBY scheme, those enrolled can use their BPL-card in any of the hospitals enlisted for the program, in any part of the country, and seasonal migration is accommodated by providing an option for enrolling in multiple facilities ("Rashtriya swasthya", 2016). No clarity was found on whether these people were unaware of the possibility to use it in any state and district or whether they had encountered problems trying to use it outside of their home districts. Based on my discussions with local professionals in the health sector, either scenario seems possible. Whichever is the case, both of them are structural challenges in the RSBY scheme that undermine access to health care services despite its objective of easy access.

The experiences of the workers followed the national pattern also in terms of quality. The quality of care in the public sector was seen as a structural barrier among the internal migrants. Delays in treatment and lack of proper medicine lead many to avail services in the private sector despite the higher prices. This is again connected to financial barriers as low quality drives the workers to spend more on their care.

*S: …The public funded hospital, where the cost of medicine, the cost of services is very negligible or it is free of cost but there is actually lot of delays. Like the service they provide is very slow, compared to private hospitals where they provide quick services, the moment you pay money you get everything. But in government hospital it's free of cost so they neglect. (***Male 18, Odisha)**

H: …At times they don't have the medicine with them, at the moment, so they call them later, like you should come later for the medicine. So... that is also one of the reasons –

S: In public hospitals. **(Male 26, Bihar)**

As these sections of financial and structural barriers reveal, many workers did not find the supply side of access to health care sufficient. Another supply side factor of access, and a structural barrier to it, is the way in which information was shared to the workers. It can be seen as both a structural barrier

in terms of how the services and information sharing is done, and as a cognitive barrier regarding how the workers are able to utilize the information provided. I take the latter viewpoint and examine it in the next section as a cognitive barrier.

6.3 Cognitive barriers

Many workers felt that their knowledge of health care providers and possibilities were more limited in their current place of residence than in their home towns and villages. They were not aware of any programs targeted at them and most have very limited knowledge of local health facilities. Information about health and health services was in general mainly acquired through the community; from neighbors, friends and co-workers. Information from health care professionals or the system had a much lesser role for example when deciding which services to use. As their social networks were now smaller compared to those in their home locality, they were lacking community-based knowledge. In this way migration created cognitive barriers in access to health care by limiting the scope of information provided in a format that is most familiar and accessible to them.

> *H: Eh, he says like he knows about health services better in Bihar he's giving an example there is a very big hospital in Patna and I think he's trying to say like there are neurosurgeons also in that hospital so and there's other hospitals also so he's more... oriented regarding the hospitals back at Bihar.* **(Male 55, Bihar)**

> *S: ...and in home town they'll be knowing much better about the hospitals and health care centers than this place.* **(Female 30, Karnataka)**

A lack of information on health creates a challenge for the approachability of health services as it can mean that people don't have enough knowledge to determine when to seek help to their problems. There were cognitive barriers limiting the access to information from health care personnel or "the system" (for example posters and flyers at health service facilities). A clear cognitive barrier in terms of health seeking and access to health-related information was the mode of communication and sharing of knowledge, which particularly occurred in two limiting ways; illiteracy and lack of

language skills. Some workers, all of whom were women, had no formal education and were illiterate which made them unable to comprehend written information. Because of this they felt that they need personal, live contact with a health care professional to get information about their treatment or health in general. Some men wished to get information in video format using their mobile phones which also could be linked to their low skills or confidence in reading Hindi. Even videos wouldn't be helpful for some of the women, as they don't own any technological devices such as television, radio or mobile phones.

> *S: The government doctors do, they don't counsel much, they just give medicines and they don't even bother explaining what is up. So… they'll say like it's written in the file you read that but they can't understand it, what is written there.* **(Female 30, Karnataka)**

> *S: If any information needs to be distributed, she won't come to know anything in first hand because she is not being accessed to any of the technology, she doesn't have cellphone she doesn't get to see the news, she doesn't read newspapers.* **(Female 23, Karnataka)**

Most inter-state migrants who didn't speak the local languages Kannada and Tulu were able to communicate with health care professionals in Hindi (one of the two official languages of the country). That is why they didn't see language as a barrier. It must be noted, however, that workers who were not comfortable speaking in Hindi or Kannada were not interviewed as the interviews were translated between English and Hindi or between English and Kannada. Nevertheless, some workers still found the lack of understanding of the local languages a challenge.

> *H: He says they wouldn't even find about the schemes because the information is not shared properly and they, he doesn't understand the language.* **(Male 19, Bihar)**

These challenges of construction workers stemming from lack of information and ability to access and comprehend the information that is available are excellent examples of the concept of cognitive barriers in the health care access barriers model. Cognitive barriers, independently or together with other barriers, hinder people's access to care by creating an environment where the use of services is not possible despite possible financial and structural accessibility.

7. “Government has improved very much but private is always better”: Distrust in public health services

While the health care access barriers model includes three categories of barriers - financial, cognitive and structural - one aspect of the experiences of internal migrant workers is worth its own additional element. Notions of the lack of trust in public services were so strong that it would not make justice to the experiences of the workers if it was only treated as a sub-category of structural barriers. In general, those in the most vulnerable position, with low levels of formality in employment and low income, expressed weaker views on the untrustworthiness of public health services. This supports the theoretical view of trust happening only in situations of vulnerability. However, distrust was expressed by all different groups of workers.

In this chapter I present distrust in the public health care services among workers as a challenge which is caused by, among other things, structural and cognitive factors; lack of quality and lack of responsibility. Distrust in public health services results in the majority of internal migrant workers preferring private services even though the public services are either free or low at cost. In this way it creates a financial barrier. I also explore how the untrustworthiness of public health care services is a commonly shared opinion among the participants of the study and is based on a larger idea of the trustworthiness of public services.

7.1 Quality issues

The poor image of government-ran health facilities was identified and brought to discussion by all different groups interviewed. While women from Karnataka expressed the most positive views on government-ran health services, even they considered private services to be of higher quality. The quality of public services was mostly seen as satisfactory or even very good, but private services were seen as evidently better and more efficient. That is to say, perceived service performance and quality was a big determinant of trust, as has been previously noted in India. Quality concerns varied from general notions of poor quality service to more specific issues, particularly to the unavailability of medicine and the lack of doctors.

H: …so there's government hospital as well as a private hospital and they eeh generally go to the private hospital for treatment so I asked him like why the preference so he's like he thinks the medicines or the treatment that is provided in the government hospital isn't that potent. **(Male 55, Bihar)**

H: He feels like at times, you know, he feels the medication or the treatment they are giving is not up to the mark so that's why he prefers going to private. **(Male 26, Bihar)**

As noted before in this chapter, poor quality of health service is a structural barrier hindering the access to health care. Another structural barrier among the workers interviewed for this study concerning public services in particular was long waiting times and delays in service.

S: Even the government health care providers, those are good but the only thing is they are a bit slow

M: okay

S: they perform a bit slow, and the procedures are very time-taking. **(Male 62, West Bengal)**

The workers associated these two with government-ran facilities and drew a sharp comparison between those and private facilities, which were portrayed as providing quality service in an effective and smooth manner.

7.2 Lack of responsibility

The poor image of public health services was also explained through lack of responsibility of the staff. Government employers were seen to have much less responsibility over their work and less interest in the true well-being of the patient compared to the staff in private clinics and hospitals.

In the light of theorizations of trust, this kind of an impression is cut out for creating distrust. As examined in chapter 4, trust is a combination of confidence in the performance and the intentions of another person or institution. If a person feels the intentions of a health care worker are not in her or his best interest, no matter how qualified or competent they are, they can't create a trusting relationship.

> *H: He said that his experience, what he has seen, is that at the government hospital, they don't listen to your problem but just treat you right away.* **(Male 19, Bihar)**

> *S: Private doctors actually explain what is the problem and they're like very responsible towards the patients, whereas the government doctors do, they don't counsel much.* **(Female 30, Karnataka)**

The conduct of staff of a health care facility also created a cognitive barrier in access to health care. Workers recalled that the way they were treated in government health facilities did not facilitate their understanding of their condition or aliment, as doctors did not explain them properly to them. This could become problematic regarding access to health care when patients don't have an understanding of when follow-up treatment is needed.

7.3 Shared knowledge

These issues, which are in fact structural and cognitive barriers in access to health care, led the worker to distrust the public health care system and to prefer private facilities. Despite the very strong consensus among the workers about the untrustworthiness of public services, there were very few

who were able to identify their own unsatisfactory experiences with the public service system. As a matter of fact, many recalled positive experiences with pubic health services. However, the untrustworthiness and poor quality of government services was expressed as a well-known and widely shared fact.

S: He believes that if it is in a private hospital em, though the cost is high, the doctor will take care of things. But in the government hospital people are not ready to take responsibility.

M: Okay. Does he have em, do you have experience with government hospitals or you've just heard it from somebody

R: No no. I know

H: It is his understanding

S: His understanding. He knows that

M: But you don't have personal experience --

R: No no. **(Male 27, Odisha)**

S: And then even the treatment in the government hospital was fine he was.. it was like satisfactory but –

H: he wanted to go

S: but he wanted personally to go to private hospital and get treated and he's more happy in private hospital

[discussion in Hindi]

H: see like the government treatment was working well like he didn't, you know, have any issue or anything of that sort but you know like he just get this thought –

*M: he just wants to go. (***Male 28, Bihar)**

This finding supports the previously-expressed notion that trust in public services is based less on own personal experiences and more on information from formal and informal networks; the media, friends, family and co-workers.

Suggestions from friends, family members and co-workers were important in deciding where to seek help. They are also important for assessing the trustworthiness of a public service. Since the workers used health care facilities quite rarely, their personal experiences on which to base such an assessment were very limited. Additionally, many of them reported very limited access to media, such as news. This emphasizes the role of networks, on which workers set particularized trust. Even one good or bad experience can have a big influence on how the community sees the trustworthiness of a health care service provider.

Another interesting explanation for the lack of trust given by the workers is based on a view on the society more broadly. There was a strong belief among the workers that what is free cannot be good and that a higher price equals better quality.

> *S: They feel that, private you know you pay more they will do very, they will give you very good service, pay less they provide you, you know, a little bit okay quality service. In government it is free and whatever is free is like not that good.* **(Female 30, Karnataka)**

> *H: He does not want to use government services because he doubts the quality of care and medicine because they are free. He does not want to take the risk.* **(Male 19, Bihar)**

This viewpoint turns the reason behind free public services against itself; they are provided for free to enhance access, but people are not willing to use them because they are free. It is hard to argue that this view on free services would only be the case with health services. Such notions of the incompatibility of free provision and quality performance speak for a broader view on how the

government manages and prioritizes public services and its own operations; on political trust. This could also be tied to the aforementioned lack of responsibility brought to discussion by some workers; patient satisfaction does not directly affect the income of a health care worker in the public sector as it does in the private sector, especially in the case of an individual practitioner.

Here a partly explanation for the lack of trust can be drawn from the former writing on trust in health care institutions and health care professionals, whether these are labeled as personal vs systemic trust or inter-personal vs social trust. Most workers mentioned small private clinics as their usual facilities for acquiring health care services. In such places the doctors and nurses possibly know the patient; many workers described this as having a good rapport with the doctor. In larger public facilities this may not be possible and it can therefore be more difficult to create an inter-personal trusting relationship with health care staff. As inter-personal trust is more important in creating trust for health care services than institutional trust, not getting personalized treatment can diminish trust, even if the technical quality of care is satisfactory.

7.4 Health care access barriers model revised: Distrust as a cause and effect of barriers

In chapter 6 I have described what kind of structural, financial and cognitive barriers internal migrants working in construction face regarding access to health care services. In this chapter I have presented my analysis of distrust in public health care services as an element of access to health care. Next, I will provide my understanding of a developed HCAB model with an additional fourth aspect, (dis)trust in public health services. As throughout this study, this model only considers the section of the HCAB model regarding barriers.

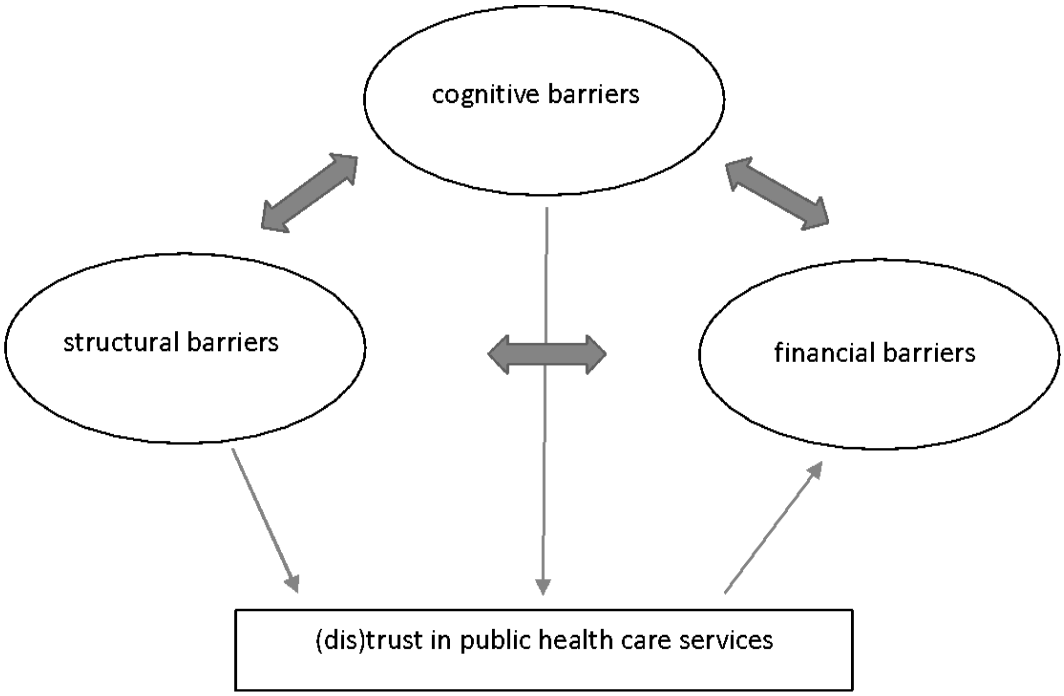

Figure 2 Health care access barriers model revised.

As Figure 2 above illustrates, distrust in public health services is connected to all three categories of barriers in the HCAB model. Based on the experiences of the internal migrant workers, there are structural and cognitive barriers in access to health care which are characteristic to public services and not to private ones. These barriers create distrust in the public health care system. The relationship of distrust and financial barriers is a different one. Distrust in services in the public sector drives people to seek health care services in the private sector, where the prices are considerably higher.

Distrust is partially created by the structural and cognitive barriers people face when they try to access public health care. These barriers do not paint the whole picture, as there are also other reasons causing distrust, such as the idea that free services are incompatible with quality care. Negative experiences with public health care services may for their part cause such views, but they are also caused by general views on the government and shared discourses about government, trust and responsibility (Manning & Guerrero, 2013; Pollitt & Chambers, 2013).

8. Discussion

In the first part of the analysis in this thesis I have applied the health care access barriers model to the data gathered among internal migrants working in the construction sector in Manipal. Contrary to my prior expectations, many workers expressed their satisfaction in the situation regarding health service access. Overall access was not very difficult for all, although all of them identified at least some challenges. The three-fold structure of the model is well able to capture three different components of the struggle internal migrant workers face in terms of health care access. Cognitive, financial and structural barriers all play a role and are connected in such a way that completely erasing one is not possible without improvements also on the other areas. For example, the structural barrier of long distance to a public health facility is connected to financial barriers - loss of income caused by the time used for the travel and the cost of travel - and to cognitive barriers - without a local network and ability to understand the language, migrant workers may not know of the existence of the facility since it is not located in their daily living environment. This example also shows how both supply and demand side factors can hinder or advance access (see e.g. Levesque et al., 2013). Understanding the connections of these different categories of barriers is essential for understanding the whole picture.

The group of people discussed in this study faced many different barriers in access to health care because they do not form a homogenous group. Their living and working conditions were not identical, and neither were the challenges regarding health care service use. Looking at the experiences of the workers through the lenses of migration, employment and gender helps us to see patterns that speak about a phenomenon larger than this particular group. Migration, level of informality of employment and gender all caused or strengthened some barriers. Moreover, they intertwined creating a situation of overall vulnerability.

Gender, more particularly being a woman, indirectly strengthens a cognitive barrier to health care. Illiteracy makes it more difficult to seek, attain and understand the need for health care. While illiteracy affects all people, it is a gendered phenomenon as 57 percent of adult women in India all illiterate compared to 32 percent of men (UNESCO Institute of Statistics, 2019). As demonstrated by the data, women's access to health care is influenced by the broader gendered issues in the society; low wages, lack of education and, influenced by that, lack of employment. The gender imbalance in

health care access and use has been widely noted before (Srivastava & McGuire, 2016; World Economic Forum, 2018, p. 11–12), and the results of this study support these previous studies.

Migrants working in informal work in the construction sector faced different barriers in access to health care depending on the level of informality of their employment. Those with the most formal type of employment arrangements had better access to health care in multiple ways. They got information about health and health care services which helps to overcome cognitive barriers. The more the employer covers costs for health care, the smaller are the financial barriers that the workers face. When an employer offers either transportation to a health facility or paid sick leave, the structural barrier of long distance becomes less significant.

The financial barrier of costs of both health care and medicine affected women and those with the lowest level of formality in their employment for the same reason. These two groups, which are largely overlapping but not entirely the same, had the lowest level of income and therefore the costs of health care make up a larger proportion of their financial resources. This result also supports findings from previous studies: access to health care is known to be more problematic for those with fewer financial resources (e.g. Arokiasamy & Pradhan, 2013; Borah, 2006, p. 928; Kundu, 2010; Mohindra, Narayana, & Haddad, 2010). The financial barrier is also recognized by the government and a reason for the provision of free or cheap services (Ministry of Health and Family Welfare, 2017; NITI Aayog, 2017, p. 144–151).

Migration caused barriers to health care access among the workers, as has been previously noted (Deshingkar & Akter, 2009, p. 44–46; UNESCO, 2013, p. 7-13). Among the group studied, the barriers caused by migration were mainly cognitive. Their knowledge of health care providers and possibilities in the area was more limited than in their home villages, and also language posed difficulties. There were no notable differences between those who came from Karnataka and those who came from other states. The unawareness of the possibility to use the BPL card also in their current place of residence and the lack of knowledge of local services showed that public communication about the effects and possibilities of migration is needed also from the perspective of health.

An unexpected finding of the study was the strong role of trust in public health care services in the context of health care access. To understand how the barriers function, trust must be taken into

account as both a cause and an effect. Distrust was based on perceived lack of quality, perceived low levels of responsibility and on shared knowledge in the community. It creates financial barriers to health care access as people opt for private services, which are considerably more expensive. High health-related expenses can push even those who are above the poverty line into poverty (Carg, 2014). In previous studies trust has not been found to be connected to patient characteristics (Hall et al., 2001, p. 627–628). Interestingly, in this study trust was higher, albeit still low, among the people with fewer resources to use private services. Their position of vulnerability forces them to trust the services that are available to them. Trust in health care providers requires the truster to accept their vulnerability (ibid., p. 616), and workers with more resources have more possibilities to choose from and hence less vulnerability.

This study, as all studies, is faced by some limitations that limit its applicability. Working as an "outsider" on a topic that requires understanding of larger societal processes, I may have misunderstood or misinterpreted the meanings behind my interviewees' responses. Research is, however, always colored by the researcher's background, knowledge and presuppositions (e.g. Graneheim & Lundman, 2004, p. 106; Tuomi & Sarajärvi, 2018, p. 109), and that should not be a reason to undermine the results of the study. Yet, I encourage the reader to read the analysis with a critical mindset to acknowledge possible drawbacks. A case study such as this one can never be directly generalized and applied to all people and situations. A critical mindset is needed in particular with the conclusions I have made about characteristics such as migration. Due to the lack of a control group of locals, I have not been able to compare the viewpoints of migrants and locals in Manipal. Additionally, issues or mistakes relating to language and translation are possible.

In this thesis I have presented my revised version of the HCAB model. It is daring to do this based only on this single case study. Therefore, I encourage other researchers to test its applicability to different settings to be able to define its scope and appropriateness. In the last chapter, I give my further remarks on the future direction of the discussion on health care access in both research and policy.

9. Conclusion

In this thesis I have examined what kind of barriers internal migrants who work in the construction sector in India face that hinder their access to health care services. Furthermore, I have analyzed how these barriers are related to each other and what is the role of distrust in public health care services in this context. I have found that there are multiple structural, financial and cognitive barriers that hinder access to care among this group of people. Migration, employment in the informal sector and gender also create and strengthen barriers. I have also found that structural and cognitive barriers create distrust in public health care services, which again creates a financial barrier to health care access.

India has set a target of reaching universal health coverage (Ministry of Health and Family Welfare, 2017). For this goal to be fulfilled, and for the enhancement of the health of Indians overall, action must be taken to counter the barriers presented in this study. Access to health care, as in any question related to social policy, should not be examined as an isolated concept. The discussion on trust presented in this thesis is an example of how social services operate in the field of larger societal forces. These forces, be it trust, or socio-economic and gender equality, for example, create the conditions in which public policies can be implemented. Hence, to advance the access of vulnerable groups to health care services, their situation in the society must be evaluated and improved as a whole. In the case of internal migrant workers, social policies such as a comprehensive migration strategy, that includes the aspects of social protection, and a comprehensive social protection system for those in the informal sector could be such improvements. Addressing the trust deficit and improving socio-economic equality enhances access to health services (e.g. Hall et al., 2001; Mahon, 2013), which is in itself a basic component of equality (Gulliford et al., 2002; Yamin, 2016).

The fact that many of the interviewed workers did not explicitly name any barriers or see their access to health care as problematic does not undermine the importance of research among this vulnerable population. As is typical to qualitative research, this case study does not aim at finding an answer that explains the whole question. Instead, this study highlights barriers that are faced by some of these workers and, since this study shows they exist, we can claim that they can and may be faced by many others. A special emphasis should be put on the finding that many barriers are more significant for people with a lower socio-economic status; informality of employment, income and literacy are some elements that strengthened barriers to care. The situation of these people is already more difficult than

others' due to these factors, so the issue of health care access should not be downplayed if equality ought to be prioritized, even if the number of people is low. Furthermore, the finding that the group of internal migrants working in construction is not homogenous regarding health care access underlines the need to treat them as a diverse group also in other policy areas.

Although giving a good frame for the analysis, when applied to the contexts of this study the health care access barriers model lacks a focus on larger societal forces. The model does not explicitly exclude other concepts such as trust, but it also does not note them as important factors in the creation and sustaining of the three categories. It would be easy to argue that the model does not consider the realities of low- and middle-income countries. This might be part of the truth, because the model is largely based on studies done in so-called Western countries. However, as the discussion on trust in public health care services in chapter 4 shows, distrust is present all over the world and future research on the role of trust should not only be limited to only low- and middle-income countries.

Without focusing on the public's trust towards public services and public health care services in particular, attempts to enhance health care access by reducing the three sets of categories will not take policy-makers very far. Trust adds an important element to the health care access barriers model because it gives an explanation of how structural, cognitive and financial barriers are connected to each other. In this specific context among internal migrants working in the construction sector in one particular town in India, trust emerged as an integral question. This finding does not only tell about the importance of trust, but gives way for further research in which other similar concepts could be found. Trust may not be as relevant in all other contexts, but there might by another phenomenon that plays an important role in access to health care in a specific time, place, society and population. In order to find such factors and to better understand what constitutes access in different societies, research is needed among diverse groups of people in a variety of settings. With a qualitative approach, researchers may be able to direct their focus on topics that may not at first be visible.

The challenges and needs for improvement in health care provision in terms of accessibility, quality, financing and human resources are well known and documented by the Indian government (e.g. Ministry of Health and Family Welfare, 2017). The sources of distrust in public health services are not out of the reach of policy-makers. As this study shows, special emphasis must be set on the public's trust in public health care services. This does not happen only through practical changes such as improvements in quality of equipment and number of staff. Since trust is a combination of

confidence in skills and intentions, focusing solely on quality issues leaves the second part of the equation unaddressed. Wider action must be taken to restore the public's trust in public and subsidized services in general. Distrust is not only caused by the operations of the health care system, but in the society more broadly (Calnan & Rowe, 2007; Mahon, 2013).

Nevertheless, there are improvements that can be made in terms of quality of services to specifically target the access to health care services of vulnerable groups, such as the migrant construction workers. Starting with sufficient education and training of health care professionals and regulation of qualifications and licenses and continuing with proper management, regulation and supervision of operations can enhance quality, create an environment of responsibility and hence create trust among the public. These actions not only increase trust, but also directly enhance access to health care. By ensuring that the facilities, human and material resources and their availability are on an adequate level, central, state and local authorities could significantly enhance vulnerable people's access to health care services, and in this way increase equality in India.

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Appendices

Appendix 1 - Participant information sheet

Participant information

Project title: The use of health services by inter-state migrant working in the construction sector in a southwestern Indian city

This study is the master's thesis of Maija Santalahti from the Tampere University in Finland. It is about the use of health services of inter-state migrants working in construction sites in Manipal. About 12 workers will be interviewed and their experiences will be analyzed. The thesis also includes theoretical aspects about health services. Its aim is to understand better how this group uses and wishes to use services. The study is done in collaboration with the Prasanna School of Public Health, Manipal Academy of Higher Education.

All interviews are confidential. They will be recorded and the recordings are only available to the researcher and the supervisors. Names or other personal information will not be included in the thesis. The thesis is written so that respondents cannot be identified in the final text. After the thesis is published, all recordings are destroyed. No responses or personal information is shared with local authorities.

Participating in the study does not affect a respondent's medical or legal rights. Participants are not given financial or other compensation. By participating, individuals can help increase academic understanding of the needs of inter-state migrant construction workers. Participation in the study will not have physiological effects on the participant. Minimal psychological discomfort is possible.

Participation in the study is completely voluntary. Respondents can decide to not answer any of the questions asked. Respondents can also at any time decide to withdraw their interview material from the study without giving any reason. If a respondent wishes that their answers are not used in the study, he/she can contact [name and contact details] at any time after the interview.

The study will be published in English at the Tampere University in Finland. It will also be available online.

Appendix 2 – Informed Consent Form

INFORMED CONSENT FORM

Project title: Use of health services by inter-state migrants working in the construction sector in a southwestern Indian city

I confirm I have read the Participant Information Sheet for the above study and its contents were explained and I have had the opportunity to ask questions and received satisfactory answers.

I understand that my participation in the study is voluntary and that I have the right to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

I agree to take part in the above study. I confirm that I have received a copy of the Participant Information Sheet along with this signed and dated informed consent form.

I consent to audio-recording of my interview understanding that the principal investigator will ensure my confidentiality. ☐

Name of the Research Participant :

Age of the Research Participant :

Address of the Research Participant :

Occupation :

Annual Income of the Participant :

Name & address of the nominee(s) and his relation to the Participant :

_____

_____ _____

Signature of the research subject Date

_____ _____

Name & Signature of the witness Date

_____ _____

Name & Signature of the person explaining the consent Date

Appendix 3 – Interview frame

This is a broad frame on which the interviews were based. However, all interviews were different. Not all of these questions were asked from all participants and interviews also included questions that are not included in this frame.

Interviews with migrant workers

Background information:
Age
District and state of origin
Time of stay in Karnataka: How long have you lived here? Would you like to tell me how you came to work here?
Family: Who belongs to your family? Who do you live with here?
Do you possess an ID card?

Experiences in Manipal
Have you been sick while you have been here? Or injured? Can you tell me what happened?

What did you do when you got sick?
Have you seen a nurse or a doctor? Where?
Did you get good care/treatment?

Do you ever buy medicine? What and where?
Have you helped others who have gotten sick? Can you tell me about it?

Can you tell me what services there are that you can use?
Are there services that are only for construction workers?
Have you ever had problems with health care? Why?
If you got very sick, what would you do? Where would you seek help?
Do you think you would be able to find help?

Experiences elsewhere
Can you tell me about your health in (place of origin)?
What would you do if you got sick in (place of origin)?

Observations
Can you tell me what other people usually do when they are injured or sick?
Have you seen that other people have had any problems?

What kind of services do you need?
Is there something else you would like to tell?